State Fiscal Year 2023 External Quality Review Technical Report

for Medicaid Health Plans

April 2024

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1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality, timeliness, and accessibility of care and services they provide, as mandated by Title 42 of the Code of Federal Regulations (42 CFR) §438.364. To meet this requirement, the Michigan Department of Health and Human Services (MDHHS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and produce this annual report.

The Behavioral and Physical Health and Aging Services Administration (BPHASA) within MDHHS administers and oversees the Michigan Medicaid managed care program; specifically, the Comprehensive Health Care Program (CHCP), which contracts with nine MCEs, referred to as Medicaid health plans (MHPs), to provide physical health and mild-to-moderate behavioral health services to Medicaid members in Michigan. The MHPs contracted with MDHHS during state fiscal year (SFY) 2023 are displayed in Table 1-1.

Table 1-1—MHPs in Michigan

MHP Name	MHP Short Name
Aetna Better Health of Michigan	AET
Blue Cross Complete of Michigan	BCC
HAP Empowered[1-1]	HAP
McLaren Health Plan	MCL
Meridian Health Plan of Michigan	MER
Molina Healthcare of Michigan	MOL
Priority Health Choice	PRI
UnitedHealthcare Community Plan	UNI
Upper Peninsula Health Plan	UPP

[1-1] HAP Empowered (HAP) transitioned to HAP CareSource (HCS) effective October 1, 2023. As HAP Empowered was the existing name of the MHP during the implementation of the EQR activities for this annual EQR technical report, HAP Empowered or HAP is referenced throughout.

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment that were performed by HSAG were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the "CMS EQR Protocols").[1-2,1-3] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to the quality, timeliness, and accessibility of care and services. Effective implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective high-value care and to achieve higher performing healthcare delivery systems for their Medicaid members. For the SFY 2023 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each MHP. Detailed information about each activity's methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS EQR Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MHP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects (CMS EQR Protocol 1)
Performance Measure Validation (PMV)[1-4]	This activity assesses whether the performance measures calculated by an MHP are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures (CMS EQR Protocol 2)

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Mar 7, 2024.

[1-3] HSAG updated the EQR methodologies to align with the 2023 CMS EQR Protocols published in February 2023. However, for the SFY 2023 activities initiated with the MHPs prior to the release of the 2023 CMS EQR Protocols, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols (https://www.medicaid.gov/sites/default/files/2023-03/2019-eqr-protocols-updated.pdf) and initiated discussions with MDHHS, as appropriate, to align the methodologies to the 2023 CMS EQR protocols.

[1-4] The MHPs contract with a National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS®) (HEDIS® is a registered trademark of the NCQA) vendor annually to undergo a full audit of their HEDIS reporting processes. As such, the results of each MHP's HEDIS audit are used for the EQR in lieu of completion of the mandatory PMV activity described in 42 CFR §438.358(b)(ii).

Activity	Description	CMS EQR Protocol
Compliance Review[1-5]	This activity determines the extent to which an MHP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance With Medicaid and CHIP [Children's Health Insurance Program] Managed Care Regulations (CMS EQR Protocol 3)
Network Adequacy Validation (NAV)	This activity assesses components of network adequacy in alignment with the priorities of the State.	Protocol 4. Validation of Network Adequacy[1-6] (CMS EQR Protocol 4)
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by an MHP.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan (CMS EQR Protocol 5)
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-7] Analysis	This activity assesses member experience with an MHP and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys (CMS EQR Protocol 6)
Quality Rating	This activity assigns a quality rating (using indicators of clinical quality management; member satisfaction; and/or plan efficiency, affordability, and management) to each MHP serving Medicaid managed care members that enables members and potential members to consider quality when choosing an MHP.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans[1-8] (CMS EQR Protocol 10)

[1-5] The compliance review activity was performed by MDHHS. MDHHS provided HSAG with the results of the compliance review activity to include in the annual EQR.

[1-6] This activity was mandatory effective February 2024 with the creation of CMS' EQR Protocol 4. HSAG's approach to conducting NAV activities in SFY 2023 was tailored to address the specific needs of MDHHS by focusing on areas selected by MDHHS to assess network adequacy. Future NAV activities will be conducted in full alignment with CMS EQR Protocol 4 and will be included in the EQR technical report for SFY 2024.

[1-7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[1-8] CMS has not yet issued the associated EQR protocol.

Michigan Comprehensive Health Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2023 activities to comprehensively assess the MHPs' performance in providing quality, timely, and accessible healthcare services to Medicaid members. For each MHP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MHP's performance, which can be found in Section 3 of this report. The overall findings and conclusions for all MHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Medicaid managed care program specific to the CHCP. Table 1-3 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for MDHHS, to drive progress toward achieving the goals of Michigan's Comprehensive Quality Strategy (CQS)[1-9] and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to its Medicaid managed care members.

Table 1-3—Michigan CHCP Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1—Ensure high quality and high levels of access to care	**Conclusions:** While MDHHS required the MHPs to report on an extensive list of Healthcare Effectiveness Data and Information Set (HEDIS)[1-10] performance measures (refer to Appendix B for results and analysis of all measures), it identified a subset of performance measures of focus for this annual EQR within the Child & Adolescent Care, Women—Adult Care, and Living With Illness domains. All domains demonstrated strengths of the CHCP. • Within the Child & Adolescent Care domain, four rates for the *Well-Child Visits in the First 30 Months of Life* and *Child and Adolescent Well-Care Visits* performance measures ranked between the 50th and 74th Medicaid Quality Compass[1-11] percentile, with four rates also demonstrating a statistically significant improvement from the prior year. • Four rates under the Women—Adult Care domain ranked between the 50th and 74th Medicaid Quality Compass percentile and one ranked between the 75th and 89th percentile. Further, all five rates within this domain for *Chlamydia*	☒ Quality ☒ Timeliness ☒ Access

[1-9] The 2020–2023 MDHHS CQS was submitted to CMS and published on the MDHHS website in January 2021. Due to the timing of the EQR activities, and at the direction of MDHHS, HSAG used the 2020–2023 MDHHS CQS for the 2022–2023 EQR assessment. However, the 2023–2026 MDHHS CQS was submitted to CMS in October 2023 and has replaced the 2020–2023 version on MDHHS' website. The 2023–2026 MDHHS CQS is now available at: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=c062404614184b219a8e4b1d6ddd520a.

[1-10] HEDIS® is a registered trademark of NCQA.

[1-11] Quality Compass® is a registered trademark of NCQA.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Screening in Women, *Cervical Cancer Screening*, and *Breast Cancer Screening* demonstrated a statistically significant improvement from the prior year. • Within the Living With Illness domain, the CHCP demonstrated strengths in the management of diabetes and hypertension. All but one rate for the *Hemoglobin A1c Control for Patients With Diabetes*, *Eye Exam for Patients With Diabetes*, *Blood Pressure Control for Patients With Diabetes*, *Kidney Health Evaluation for Patients With Diabetes*, and *Controlling High Blood Pressure* performance measures ranked between the 50th and 74th Medicaid Quality Compass percentile, with seven rates demonstrating a statistically significant improvement from the prior year. Further, while the rate for *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* only ranked between the 25th and 49th percentile, the rate also improved compared to the prior year's rate. Overall, the CHCP has improved the percentage of children and adolescents who received well-care visits, women who received screenings for cancer and sexually transmitted infections (STIs), and members who received appropriate management of diabetes and hypertension. The CHCP should continue to build on this momentum and continue efforts to improve member engagement in care; and therefore, improve performance levels based on comparisons to national percentiles. However, the results of the NAV activity indicated that some of the CHCP's members may experience challenges contacting or scheduling appointments with primary care providers (PCPs), pediatric providers, and obstetrics/gynecology (OB/GYN) providers due to invalid provider telephone or address, provider type/specialty, and/or insurance information. Further, of providers responding to the secret shopper survey and accepting the insurance and new patients, only 61.5 percent of providers offered the caller an appointment and only 76.3 percent of those appointments met MDHHS' established appointment time frame standards (i.e., 30 business days for routine care appointments and seven business days for prenatal care appointments). Long wait times for appointments may lead to patient dissatisfaction. Further, for the CAHPS measure, *Rating of Personal Doctor*, the CHCP only received a *Fair* or *Poor* rating for the adult Medicaid, child Medicaid, and Healthy Michigan Plan (HMP) populations. While many members were receiving appropriate care and services	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	as demonstrated by the HEDIS results, dissatisfaction with providers may discourage members from making appointments for preventive care or the management of chronic conditions. **Recommendations:** MDHHS has updated the 2023–2026 CQS to include measurable quality measures that support achievement of the goals and objectives of Goal #1. The establishment of measurable quality measures will allow MDHHS to complete an evaluation of the effectiveness of its CQS using quantitative data. As such, HSAG recommends that MDHHS include all validated performance measures included as a Quality Measure under each goal and objective within the CQS as focus measures for each annual EQR. Additionally, to keep the MHPs accountable to the goals and objectives of the CQS, MDHHS could contractually require the MHPs to include a specific section dedicated to the CQS within each MHP's annual quality assessment and performance improvement (QAPI) program evaluation. MDHHS should require this section to include an analysis of the impact, positive or negative, the MHP had on meeting the goals and objectives of the CQS using the MHP's performance results for the quality measures established by MDHHS for the CHCP program. For any quality measure for which the MHP had a negative impact, the MHP should include an initiative in the QAPI program to improve performance. This recommendation applies to all goals of the CQS and is not specific to Goal #1.	
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** To promote patient-centered medical homes (PCMHs) as an integral component of the delivery system, MDHHS contractually requires the MHPs to support the transformation of primary care practices into PCMHs and to commit to increasing the percentage of members receiving services from PCMH-designated practices. Additionally, MDHHS requires members receiving Children's Special Health Care Services (CSHCS) to be assigned to primary care practices that provide family-centered care (i.e., family-centered medical homes). Patient-centered and family-centered care is a model of care to ensure care for members and families is managed across a continuum of care and specialty services. MDHHS monitors various requirements that support the objectives of Goal #2 through the compliance review activity; and specifically, through the Providers, Members, and Quality standards (e.g., care coordination, addressing social determinants of health [SDOH], navigating community resources, referrals to behavioral health and substance use disorder [SUD] providers, and access to culturally competent care). The SFY 2023 compliance review	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	results demonstrated high performance for the CHCP as the statewide rate for the Providers, Members, and Quality standards were 94.7 percent, 97.7 percent, and 99.5 percent, respectively. However, the findings for SFY 2023 CAHPS activity demonstrated mixed results with member experiences of care for most measures across the adult Medicaid, child Medicaid, CSHCS, and HMP populations. Particularly for the child Medicaid population, there are substantial opportunities to improve member experiences related to their healthcare and personal doctor as the CHCP received a *Poor* rating for the related measures, *Rating of All Health Care* and *Rating of Personal Doctor*. MDHHS has included several CAHPS measures to the 2023–2026 CQS to allow for a more targeted evaluation of MDHHS' progress in meeting Goal #2. MDHHS has also updated the 2023–2026 CQS to include other measurable quality measures, in addition to CAHPS measures, for the CHCP to support achievement of the goals and objectives of Goal #2. The establishment of measurable quality measures will allow MDHHS to complete an evaluation of the effectiveness of its CQS using quantitative data. **Recommendations:** Federal Medicaid managed care regulations require managed care entities to conduct PIPs that focus on clinical and non-clinical areas. As such, HSAG recommends that MDHHS identify a poor performing CAHPS measure (e.g., *Rating of All Health Care* and *Rating of Personal Doctor* for the child Medicaid population) and require the MHP to implement a non-clinical PIP that focuses on improving member experience for the selected measure. The identification of barriers and subsequent implemented interventions should support progress toward achieving Goal #2.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)	**Conclusions:** In support of Objective 3.2: *Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations*, MDHHS requires each MHP to develop and execute a transition of care policy for when members transition from fee-for-service (FFS) to the MHP or from one MHP to another. The MHPs' transition of care policy is monitored by MDHHS through the compliance review activity. Each MHP's policy must be available to the public, cover out-of-network providers, ensure continuation of services, and ensure transitional supply of medications. The SFY 2023 compliance review activity confirmed that the MHPs met MDHHS' expectations as all MHPs received a *Met* score for element *3.27 Transition of Care Policy*. Element *3.2 Member*	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Handbook also requires the member handbook to inform members of the MHP's transition of care policy. All MHPs received a *Met* score for this element. Additionally, member satisfaction with care coordination can be evaluated through the CAHPS activity. The SFY 2023 CAHPS results indicated that more members reported that their PCP seemed informed about the care they received from other providers as demonstrated by a *Good* rating (i.e., at or between the 50th and 74th percentiles) for the *Coordination of Care* measure for the adult Medicaid and HMP populations. Further, to support collaboration between the MHPs and PIHPs, MDHHS has established Integration of Behavioral Health and Physical Health Services performance metrics as part of a Performance Bonus: *Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH)*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)*, and *Implementation of Joint Care Management Processes*. Timely follow-up care following an inpatient or emergency room stay supports effective care coordination during transitions of care. Further, in support of Objective 3.3: *Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes* and through the *Implementation of Joint Care Management Processes* metric, MDHHS requires the MHPs to develop joint care plans with the PIHPs who provide behavioral health services, through MDHHS' care management tool within its information system (IS) platform, CareConnect360 (CC360). MDHHS contractually requires MHPs to utilize CC360 to document a jointly created care plan and to track contacts, issues, and services regarding members shared by both entities (i.e., MHP and PIHP) who have significant behavioral health issues and complex physical comorbidities. While the results of the Performance Bonus are not available to HSAG through this annual EQR, the *Effectiveness Evaluation Appendix C—Results of 2020-2023 CQS Goals & Objectives Program Evaluation Assessments* as reported through the 2023–2026 CQS, indicated that the CHCP met two of the three objectives under Goal #3. The evaluation further suggested that while shared MHP and PIHP metrics are examples of improving transitions of care among providers and systems, the separation of the behavioral	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	health system and physical health system under the CHCP makes integration of care difficult. **Recommendations:** To ensure the CHCP does not manage and coordinate care through siloed programs, HSAG recommends that MDHHS continue to strategize innovative ways to further integrate the physical health system and the behavioral health system. Additionally, MDHHS has updated the 2023–2026 CQS to include *Implementation of Joint Care Management Processes* as a quality measure to support Goal #3 with the 2026 statewide performance target being *All applicable plan combinations to have at least one shared care plan in CC360*. This implies that only one member per plan combination over a three-year period (i.e., 2023–2026) would need to have a joint care plan created to meet the statewide goal. While having a joint care plan may have a positive impact on health outcomes for a member (i.e., one member per plan combination), it does not appear that this target would substantially drive quality improvement for the CHCP. HSAG recommends that MDHHS re-evaluate the appropriateness of this performance target or further clarify the intent or rationale behind setting this as MDHHS' 2026 goal. MDHHS has also included *Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH)* as a quality measure for Goal #3 in the 2023–2026 CQS. While a 2026 statewide performance target has been established, a baseline rate has yet to be determined. HSAG recommends that MDHHS proceed with establishing the baseline rate for this measure and re-evaluate the appropriateness of the 2026 goal based on the baseline rate. Further, for the CSHCS population, MDHHS has established 2026 statewide performance targets for the *Coordination of Care* and *Global Rating of Health Care* quality measures (i.e., CAHPS measures). However, the 2026 targets do not drive quality improvement as they are a lower rate than the baseline rate. HSAG recommends that MDHHS re-evaluate the appropriateness of setting a three-year performance minimum performance target lower than the CHCP's baseline rate. As CMS has placed strong emphasis on interoperability through the CMS Interoperability and Patient Access Final Rule (CMS-9115-F), and most recently, the CMS Interoperability and Prior Authorization Processes Final Rule (CMS-0057-F) enhancing the application programming interface (API) requirements, HSAG also recommends that MDHHS consider potential quality measures related to the APIs to include in future revisions of the 2023–2026 CQS to promote Goal #3. For example, as CMS-9115-F is requiring	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	reporting of Patient Access API usage, MDHHS could consider this as a future quality measure to support Goal #3. Lastly, the API requirements are included under 42 CFR §438.242 Health information systems, which requires Medicaid managed care plans to implement the APIs and must be reviewed as part of the compliance review activity. However, in review of MDHHS' compliance review methodology, the API requirements are not currently included in the compliance review activity. HSAG recommends that MDHHS evaluate each MHP's compliance with the API requirements and incorporate the API requirements in future compliance review activities.	
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** MDHHS contractually requires the MHPs to participate in the Medicaid Health Equity Project. MDHHS publishes an annual health equity report, most recently in August 2023, which reports select performance measure data stratified by four racial populations (Asian American/Native Hawaiian/Other Pacific Islander, African American, American Indian/Alaska Native, and White) and one ethnicity (Hispanic). The August 2023 report,[6-12] reflecting the measurement year (MY) 2022 rate, identified that the African-American Medicaid managed care population had significantly lower rates than the White population in nine of the 11 measures, with the largest disparity occurring for the *Childhood Immunization Status—Combination 3* measure. MDHHS uses this data to initiate health equity projects. The MHPs are also contractually required to develop a health equity program with an annual workplan to narrow disparities. Health equity measures have been increasing in weight and priority in determining MHP performance bonus and incentives. The *Childhood Immunization Status—Combination 3* measure was included in the SFY 2023 MHP Performance Bonus program. Additionally, for SFY 2023, the MHPs were responsible for continuing their PIP topics to address healthcare disparities. Through the MHPs' analyses of their data, seven of the nine MHPs identified an existing disparity.[1-13] As demonstrated through the SFY 2023 PIP validation, all nine MHPs designed a	☒ Quality ☒ Timeliness ☒ Access

[1-12] Michigan Department of Health and Human Services, Behavioral and Physical Health and Aging Services Administration. Medicaid Health Equity Project Year 11 Report on MY 2020 Data All Medicaid Health Plans, August 2023. Available at: https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/MY2020-Medicaid-Health-Equity-Project-Year-11-Report-All-Plans.pdf?rev=f50322a580a74b0ca8e77ab65918dc13&hash=40A029FC7867E98A212517FA1262FD21. Accessed on: Jan 19, 2024.

[1-13] Six of the seven MHPs identified a racial/ethnic disparity, and one MHP identified a disparity by geographical region.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	methodologically sound PIP and implemented interventions based on the barriers identified through each MHP's data analysis and quality improvement processes. Of the seven MHPs with an existing disparity, while only two were successful at eliminating the disparity during the current reporting period, five MHPs demonstrated a rate increase for their disparate population. Further, processes concerning health equity are monitored by MDHHS through the compliance review activity and specifically through elements *3.26 Diversity, Equity, and Inclusion (DEI) Assessment and Training* and *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*. The SFY 2023 compliance review findings confirmed that all MHPs met MDHHS' expectations for these two elements. A discussion of health disparities was also incorporated into the SFY 2023 focus studies. For the CSHCS focus study, MDHHS provided the MHPs with updates regarding the Medicaid Health Equity Project; and for the Quality focus study, MDHHS required the MHPs to report on initiatives being implemented to leverage the postpartum care coverage expansion to address racial and ethnic disparities in postpartum screenings and care engagement. Lastly, MDHHS has demonstrated its commitment to reduce racial and ethnic disparities in healthcare and has updated the 2023–2026 CQS to include multiple quantitative quality measures for the CHCP to support achievement of the goals and objectives of Goal #4. **Recommendations:** Through the PIP activity, while several MHPs identified a barrier and/or an intervention for the target/disparate population, it was not always clear if all barriers and interventions listed applied to a MHP's entire population or the target/disparate population. HSAG recommends that MDHHS consider requiring the MHPs to identify whether each barrier and intervention applies to the MHP's entire population or the target/disparate population specifically. HSAG further recommends that MDHHS require that each MHP identify a certain number of barriers and interventions that must specifically address the target/disparate population.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** MDHHS has established MHP performance bonuses, through Performance Monitoring Standards, the Encounter Quality Initiative (EQI), Population Health Management (PHM), Pay for Performance (P4P), a Performance Bonus, and an Alternative Payment Model (APM). The aggregated findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact these value-based initiatives and payment reform had on improving quality outcomes. However, the *Effectiveness Evaluation Appendix C—Results of 2020–2023 CQS Goals & Objectives Program Evaluation Assessments* as reported through the 2023–2026 CQS, confirmed that the CHCP met Objective 5.1: *Promote the use of value-based payment models to improve quality of care.* Under Goal #5, MDHHS established performance bonus withholds and the APM strategy as part of the performance bonus withhold with target benchmarks established for the MHPs. Additionally, MDHHS has updated the 2023–2026 CQS to include measurable quality measures for the CHCP to support achievement of the goals and objectives of Goal #5. **Recommendations:** MDHHS updated its CQS for the time span of 2023–2026 and included two performance metrics with baseline performance and performance targets for 2026 for the CHCP: *Average percentage of plan payments to providers who are in APM arrangements ("Big Numerator")* and *Average percentage of plan payments to providers that are tied to quality ("Small Numerator")*. However, the 2026 target for *Average percentage of plan payments to providers that are tied to quality ("Small Numerator")* is lower than the statewide baseline rate. It is unclear why MDHHS would set a 2026 goal (i.e., CQS Objective) lower than the baseline rate as this CQS Objective would not drive improvement. The quality measure does not appear to be an inverse measure (i.e., lower rate indicates better performance) as the measure is tied to quality of care. HSAG recommends that MDHHS re-evaluate its 2026 performance target for this quality measure and update as appropriate or include the rationale for establishing a target lower than the baseline rate.	☒ Quality ☐ Timeliness ☐ Access

2. Overview of the Michigan Medicaid Managed Care Program

Managed Care in Michigan

BPHASA within MDHHS administers and oversees the Michigan Medicaid managed care programs. Table 2-1 displays the Michigan Medicaid managed care programs, the MCE(s) responsible for providing services to members, and the populations served.

Table 2-1—Medicaid Managed Care Programs in Michigan

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
Comprehensive Health Care Program (CHCP)				
Medicaid Health Plans (MHPs)	Managed Care Organization (MCO)	1915(b)	July 1997	MHPs provide comprehensive healthcare services to low-income adults and children.
• MIChild (CHIP)		1915(b)	January 2016	MIChild is a Medicaid program for low-income uninsured children under the age of 19.
• Children's Special Health Care Services (CSHCS)		Michigan Medicaid State Plan	October 2012	CSHCS is a program within MDHHS for children and some adults with special health care needs and their families.
Healthy Michigan Plan (HMP) (Medicaid Expansion)	MCO	1115 Demonstration	April 2014	HMP establishes eligibility for Michigan citizens up to 133% of the federal poverty level who are otherwise not eligible for Medicaid at the time of enrollment.
Flint Medicaid Expansion (FME) Waiver	MCO	1115 Demonstration	March 2016	The waiver provides Medicaid coverage and benefits to individuals affected by the Flint Water Crisis.
MI Health Link Demonstration (Integrated Care Organizations [ICOs])	ICO	1915(b) & 1915(c)	March 2015	Persons fully eligible and enrolled in both Medicare and Medicaid who are over the age of 21 and reside in one of the four regions where the program is available.
MI Choice Waiver Program (Prepaid Ambulatory Health Plans [PAHPs])	PAHP	1915(c) since 1992 1915(b) since 2012	1992	The elderly or disabled adults (aged 18+) who meet the nursing facility level of care.

Medicaid Managed Care Program	MCE Type	Managed Care Authority	Date Initiated	Populations Served
Dental Health Programs				
Healthy Kids Dental (HKD) (PAHP)	PAHP	1915(b)	October 2016	The HKD program provides dental services to beneficiaries under age 21.
Adult Dental (MHPs)	MCO	1915(b)	April 2023	Medicaid beneficiaries aged 21 years and older, including HMP beneficiaries and pregnant individuals who are enrolled in an MHP, ICO, or Program of All-Inclusive Care for the Elderly (PACE) receive dental benefits through their MHP.
Behavioral Health Managed Care **Children's Behavioral Health—Bureau of Children's Coordinated Health Policy & Supports (BCCHPS)** **Adult Behavioral Health—Bureau of Specialty Behavioral Health Services (SBHS)**				
Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Services Programs (CMHSPs)	PIHP	Behavioral Health 1115 Demonstration Waiver	October 2019	Individuals with intellectual and developmental disability (I/DD), serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorder (SUD)
		1915(i) SPA [State Plan Amendment]	October 2022	
		1115 HMP	April 2014	
		Flint 1115 Waiver or Community Block Grant	May 2016	
		1915(c) Habilitation Supports Waiver (HSW), Children's Waiver Program (CWP), and Children's Serious Emotional Disturbance Waiver (SEDW)	October 2019	

Comprehensive Health Care Program

MDHHS contracts with nine MHPs in targeted geographical service areas comprised of 83 counties (divided into 10 regions) and provides medically necessary services to nearly 1.9 million Medicaid and 42,000 CHIP managed care members in Michigan.[2-1] Michigan's waiver requires managed care members to obtain services from specified MHPs based on the county of residence. MDHHS enrolls a diverse set of populations into the CHCP managed care program, including the disabled, foster children, pregnant women, and children dually eligible for Title V and Title XIX under the Social Security Act. Individuals dually eligible for Medicare and Medicaid may enroll in MHPs voluntarily. Additionally, since 2016, MDHHS implemented the HMP, which is Michigan's Medicaid expansion program. The HMP benefit package includes a comprehensive dental benefit in addition to primary, preventive, and behavioral healthcare. Michigan's stand-alone CHIP, known as MIChild, is also administered through the CHCP.

Overview of Medicaid Health Plans

During the SFY 2023 review period, MDHHS contracted with nine MHPs. These MHPs were responsible for the provision of medically necessary services to Medicaid members. Table 2-2 provides a profile for each MHP.

Table 2-2—MHP Profiles and Enrollment Data

MHP	Covered Services[2-2]	Operating Region(s)[2-3]	Number of Counties Served[2-4]
AET	All MHPs cover medically necessary services such as the following: • Ambulance • Chiropractic • Dental services • Doctor visits • Doula services • Emergency services	8, 9, 10	16
BCC		4, 6, 7, 9, 10	32
HAP		6, 10	10
MCL		2, 3, 4, 5, 6, 7, 8, 9, 10	68

2-1 December 2023 enrollment data provided by MDHHS.

2-2 Michigan Department of Health and Human Services. *A Guide to Michigan Medicaid Health Plans, Quality Checkup, January 2024*. Available at: https://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf. Accessed on: Mar 7, 2024.

2-3 Michigan Department of Health and Human Services. *Medicaid Health Plans by Region*, updated 10/01/21. Available at: https://www.michigan.gov/documents/mdhhs/MHP_Counties_Map_502832_7.pdf. Accessed on: Mar 7, 2024.

2-4 Michigan Department of Health and Human Services. *Michigan Medicaid Health Plan Listed by County*, updated 12/4/2023. Available at: https://www.michigan.gov/documents/mdch/MHP_Service_Area_Listing_326102_7.pdf. Accessed on: Mar 7, 2024.

MHP	Covered Services[2-2]	Operating Region(s)[2-3]	Number of Counties Served[2-4]
MER	• Family planning • Health checkups • Hearing and speech • Home health care • Hospice care • Hospital care • Immunizations • Laboratory and X-rays • Medical supplies • Medicine • Mental health • Physical and occupational therapy • Podiatry • Prenatal care and delivery • Surgery • Vision	2, 3, 4, 5, 6, 7, 8, 9, 10	68
MOL		2, 3, 4, 5, 6, 7, 8, 9, 10	68
PRI		4, 8, 10	23
UNI		2, 3, 4, 5, 6, 8, 9, 10	65
UPP		1	15

Quality Strategy

The 2020–2023 MDHHS CQS[2-5] provides a summary of the initiatives in place in Michigan to assess and improve the quality of care and services provided and reimbursed by MDHHS Medicaid managed care programs, including CHCP, long-term services and supports (LTSS), dental programs, and behavioral health managed care. The CQS document is intended to meet the required Medicaid Managed Care and CHIP Managed Care Final Rule, at 42 CFR §438.340. Through the development of the 2020–2023 CQS, MDHHS strives to incorporate each managed care program's individual accountability, population characteristics, provider network, and prescribed authorities into a common strategy with the intent of guiding all Medicaid managed care programs toward aligned goals that address equitable, quality healthcare and services. The CQS also aligns with CMS' Quality Strategy and the U.S. Department of Health and Human Services' (HHS') National Quality Strategy (NQS), wherever applicable, to improve the delivery of healthcare services, patient health outcomes, and population health. The MDHHS CQS is organized around the three aims of the NQS—better care, healthy people and communities, and affordable care—and the six associated priorities. The goals and objectives of the MDHHS CQS pursue an integrated framework for both overall population health improvement as well as commitment to eliminating unfair outcomes within subpopulations in Medicaid managed care. These goals and objectives are summarized in Table 2-3, and align with MDHHS' vision to *deliver health and opportunity to all Michiganders, reducing intergenerational poverty and health inequity*, and specifically were designed to *give all kids a healthy start* (MDHHS pillar/strategic priority #1), and to *serve the whole person* (MDHHS pillar/strategic priority #3).

Table 2-3—2020–2023 Michigan CQS Goals and Objectives

MDHHS CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #1: Ensure high quality and high levels of access to care		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start	Expand and simplify safety net access	**Objective 1.1:** Ensure outreach activities and materials meet the cultural and linguistic needs of the managed care populations.
		Objective 1.2: Assess and reduce identified racial disparities.
		Objective 1.3: Implement processes to monitor, track, and trend the quality, timeliness, and availability of care and services.
		Objective 1.4: Ensure care is delivered in a way that maximizes members' health and safety.

[2-5] The 2020–2023 MDHHS CQS was submitted to CMS and published on the MDHHS website in January 2021. Due to the timing of the EQR activities, and at the direction of MDHHS, HSAG used the 2020–2023 MDHHS CQS for the 2022–2023 EQR assessment. However, the 2023–2026 MDHHS CQS was submitted to CMS in October 2023 and has replaced the 2020–2023 version on MDHHS' website. The 2023–2026 MDHHS CQS is now available at: https://www.michigan.gov/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/Quality_Strategy_2015_FINAL_for_CMS_112515.pdf?rev=c062404614184b219a8e4b1d6ddd520a.

MDHHS CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
		Objective 1.5: Implement evidence-based, promising, and best practices that support person-centered care or recovery-oriented systems of care.
Goal #2: Strengthen person and family-centered approaches		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 2.1**: Support self-determination, empowering individuals to participate in their communities and live in the least restrictive setting as possible.
		Objective 2.2: Facilitate an environment where individuals and their families are empowered to make healthcare decisions that suit their unique needs and life goals.
		Objective 2.3: Ensure that the social determinants of health needs and risk factors are assessed and addressed when developing person-centered care planning and approaches.
		Objective 2.4: Encourage community engagement and systematic referrals among healthcare providers and to other needed services.
		Objective 2.5: Promote and support health equity, cultural competency, and implicit bias training for providers to better ensure a networkwide, effective approach to healthcare within the community.
Goal #3: Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)		
NQS Aim #1: Better Care MDHHS Pillar #3: Serve the whole person	Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 3.1:** Establish common program-specific quality metrics and definitions to collaborate meaningfully across program areas and delivery systems.
		Objective 3.2: Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations.
		Objective 3.3: Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes.

MDHHS CQS Managed Care Program Goals	MDHHS Strategic Priorities	Objectives
Goal #4: Reduce racial and ethnic disparities in healthcare and health outcomes		
NQS Aim #1: Better Care MDHHS Pillar #1: Give all kids a healthy start MDHHS Pillar #3: Serve the whole person	Improve maternal-infant health and reduce outcome disparities Address food and nutrition, housing, and other social determinants of health Integrate services, including physical and behavioral health, and medical care with long-term support services	**Objective 4.1:** Use a data-driven approach to identify root causes of racial and ethnic disparities and address health inequity at its source whenever possible.
		Objective 4.2: Gather input from stakeholders at all levels (MDHHS, beneficiaries, communities, providers) to ensure people of color are engaged in the intervention design and implementation process.
		Objective 4.3: Promote and ensure access to and participation in health equity training.
		Objective 4.4: Create a valid/reliable system to quantify and monitor racial/ethnic disparities to identify gaps in care and reduce identified racial disparities among the managed care populations.
		Objective 4.5: Expand and share promising practices for reducing racial disparities.
		Objective 4.6: Collaborate and expand partnerships with community-based organizations (CBOs) and public health entities across the state to address racial inequities.
Goal #5: Improve quality outcomes and disparity reduction through value-based initiatives and payment reform		
NQS Aim #3: Affordable Care MDHHS Pillar #4: Use data to drive outcomes	Drive value in Medicaid Ensure we are managing to outcomes and investing in evidence-based solutions	**Objective 5.1:** Promote the use of value-based payment models to improve quality of care.
		Objective 5.2: Align value-based goals and objectives across programs.

The CQS also includes a common set of performance measures to address the required Medicaid Managed Care and CHIP Managed Care Final Rule. The common domains include:

- Network Adequacy and Availability
- Access to Care
- Member Satisfaction
- Health Equity

These domains address the required state-defined network adequacy and availability of services standards and take into consideration the health status of all populations served by the MCEs in Michigan. Each program also has identified performance measures that are specific to the populations it serves.

MDHHS employs various methods to regularly monitor and assess the quality of care and services provided by the managed care programs. MDHHS also intends to conduct a formal comprehensive assessment of performance against CQS performance objectives annually. Findings will be summarized in the Michigan Medicaid Comprehensive Quality Strategy Annual Effectiveness Review, which drives program activities and priorities for the upcoming year and identifies modifications to the CQS.

Quality Initiatives and Interventions

Through its CQS, MDHHS has also implemented many initiatives and interventions that focus on quality improvement. Examples of these initiatives and interventions include:

- **Accreditation**—MCEs, including all MHPs and some ICOs and PIHPs, are accredited by a national accrediting body such as NCQA, Utilization Review Accreditation Commission (URAC), Commission on Accreditation of Rehabilitation Facilities (CARF), and/or The Joint Commission.
- **Opioid Strategy**—MDHHS actively participates in and supports Michigan's opioid efforts to combat the opioid epidemic by preventing opioid misuse, ensuring individuals using opioids can access high quality recovery treatment, and reducing the harm caused by opioids to individuals and their communities.
- **Health Home Models**—Michigan established three Health Home models in accordance with Section 2703 of the Affordable Care Act including the Opioid Health Home, MI Care Team, and the Behavioral Health Home. These Health Homes focus on high-need/high-cost members with chronic conditions, provide flexibility to create innovative and integrated care management models, and offer sustainable reimbursement to affect the SDOH. Federally mandated core services include comprehensive care management and care coordination, health promotion, comprehensive transitional care and follow-up, individual and family support, and referral to community and social services. Participation in the Health Home models is voluntary, and enrolled members may opt out at any time.
- **Behavioral Health Integration**—All Medicaid managed care programs address the integration of behavioral health services by requiring MHPs and ICOs to coordinate behavioral health services and services for persons with disabilities with the Community Mental Health Services Programs (CMHSPs)/PIHPs. While contracted MHPs and ICOs may not be responsible for the direct delivery of specified behavioral health and developmental disability services, they must establish and maintain agreements with MDHHS-contracted local behavioral health and developmental disability agencies or organizations. Plans are also required to work with MDHHS to develop initiatives to better integrate services and to provide incentives to support behavioral health integration.
- **Value-Based Payment**—MDHHS employs a population health management framework and intentionally contracts with high-performing plans to build a Medicaid managed care delivery

system that maximizes the health status of members, improves member experience, and lowers cost. The population health framework is supported through evidence- and value-based care delivery models, health information technology/health information exchange, and a robust quality strategy. Population health management includes an overarching emphasis on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on the SDOH, creating health equity and supporting efforts to build more resilient communities. MDHHS supports payment reform initiatives that pay providers for value rather than volume, with "value" defined as health outcome per dollar of cost expended over the full cycle of care. In this regard, performance metrics are linked to outcomes. The Medicaid managed care programs are at varying degrees of payment reform; however, all programs utilize a performance bonus (quality withhold) with defined measures, thresholds, and criteria to incentivize quality improvement and improved outcomes.

- **Health Equity Reporting and Tracking**—MDHHS is committed to addressing health equity and reducing racial and ethnic disparities in the healthcare services provided to Medicaid members. Disparities assessment, identification, and reduction are priorities for the Medicaid managed care programs, as indicated by the CQS goal to reduce racial and ethnic disparities in healthcare and health outcomes.

3. Assessment of Medicaid Health Plan Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2023 review period to evaluate the performance of the MHPs on providing quality, timely, and accessible healthcare services to CHCP members. Quality, as it pertains to EQR, means the degree to which the MHPs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to MDHHS' network adequacy standards) and §438.206 (adherence to MDHHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

HSAG follows a step-by-step process to aggregate and analyze data conducted from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MHP.

- **Step 1**: HSAG analyzes the quantitative results obtained from each EQR activity for each MHP to identify strengths and weaknesses that may pertain to the domains of quality, timeliness, and access to services furnished by the MHP for the EQR activity.
- **Step 2**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain and HSAG draws conclusions about overall quality, timeliness, and accessibility of care and services furnished by the MHP.
- **Step 3**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities as they relate to strengths and weaknesses in one or more of the domains of quality, timeliness, and accessibility of care and services furnished by the MHP.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2023 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For the SFY 2023 PIP validation activity, the MHPs continued PIP topics that focused on disparities in care, reporting Remeasurement 1 data for each specified performance indicator. MHPs with an existing disparity have a minimum of two performance indicators (a disparate sub-group performance indicator and a comparison sub-group performance indicator), and MHPs without an existing disparity have one performance indicator. HSAG conducted validation on the PIP Design (steps 1 through 6),

Implementation (Step 7 and Step 8), and Outcomes (Step 9) stages of the selected PIP topic for each MHP in accordance with CMS' EQR protocol for the validation of PIPs (CMS EQR Protocol 1). Although all steps may not be included in the validation activities for SFY 2023 for every MHP, the validation rating for each MHP incorporates all steps in the validation process.

Table 3-1 outlines the selected PIP topics and performance indicator(s) as defined by each MHP.

Table 3-1—PIP Topic and Performance Indicator(s)

MHP	PIP Topic	Performance Indicator(s)
AET	*Addressing Disparities in Timeliness of Prenatal Care*	1. Timeliness of prenatal care in rural designated ZIP Codes. 2. Timeliness of prenatal care in urban designated ZIP Codes.
BCC	*Reducing Racial Disparities Within Timeliness of Prenatal Care*	1. Black women residing in Region 10 (disparate group). 2. White women residing in Region 10 (comparison group).
HAP	*Improving the Timeliness of Prenatal Care*	Measuring the percentage of Black/African-American pregnant women who have a prenatal visit within 42 days of enrollment or within the first trimester.
MCL	*Addressing Disparities in Timeliness of Prenatal Care*	1. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for Black members. 2. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for White members.
MER	*Addressing Disparities for Timeliness of Prenatal Care: Addressing Racial Health Disparities*	1. Improve the PPC [Prenatal and Postpartum Care]-Timeliness of Prenatal Care rate for the Black (non-Hispanic) population residing in Region 6 in order to reduce the disparity to the comparison subgroup. 2. Maintain the performance of the HEDIS PPC-Timeliness of Prenatal Care performance result for eligible White (non-Hispanic) members residing in Region 6.
MOL	*Addressing Disparities for Timeliness of Prenatal Care*	1. Timeliness of Prenatal Care—Black. 2. Timeliness of Prenatal Care—White.
PRI	*Improving Timeliness of Prenatal Care for African-American Women*	1. The percentage of African-American women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health. 2. The percentage of Caucasian women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health.
UNI	*Addressing Disparities in Timeliness of Prenatal Care*	Timeliness of prenatal care for African-American/Black members in Region 10.

MHP	PIP Topic	Performance Indicator(s)
UPP	*Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members Ages 20–44*	1. Annual Ambulatory or Preventative Visit for UPP Black members. 2. Annual Ambulatory or Preventative Visit for UPP White members.

Performance Measure Validation

Each MHP underwent an NCQA HEDIS Compliance Audit™[3-1] conducted by an NCQA licensed organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's MY 2022 Volume 5, *HEDIS Compliance Audit: Standards, Policies and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the MHPs' processes consistent with the CMS EQR Protocols. To complete the validation of the performance measure process according to CMS EQR Protocol 2 for the validation of performance measures, HSAG performed an independent evaluation of the HEDIS MY 2022 Compliance Audit Report, which contained findings related to the following seven IS standards:

- IS 1.0: Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0: Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0: Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0: Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0: Supplemental Data—Capture, Transfer, and Entry
- IS 6.0: Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0: Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity

Additionally, MDHHS expects its contracted MHPs to support claims systems, membership and provider files, as well as hardware/software management tools that facilitate valid reporting of the HEDIS measures. MDHHS contracted with HSAG to calculate statewide average rates based on the MHPs' rates and evaluate each MHP's current performance level, as well as the statewide performance, relative to national Medicaid percentiles.

MDHHS provided HSAG with a selected list of HEDIS measures to evaluate the Michigan MHPs for the annual assessment. These measures were within the following three domains, and are listed in Table 3-2:

- Child & Adolescent Care
- Women—Adult Care
- Living With Illness

[3-1] HEDIS Compliance Audit™ is a trademark of NCQA.

Additional performance measures and performance measure results are included in Appendix B. HSAG used this supplemental information to assess year-over-year trending; evaluate the degree to which the MHP addressed the prior year's recommendations; and determine overall MHP-specific conclusions related to quality, timeliness, and accessibility of healthcare services.

Table 3-2—Performance Measures for Validation

Performance Measure	HEDIS Data Collection Methodology
Child & Adolescent Care	
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*	Administrative
Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, *Ages 12 to 17 Years*, *Ages 18 to 21 Years*, and *Total*	Administrative
Women—Adult Care	
Chlamydia Screening in Women—Ages 16 to 20 Years, *Ages 21 to 24 Years*, and *Total*	Administrative
Cervical Cancer Screening	Hybrid
Breast Cancer Screening	Administrative
Living With Illness	
*Hemoglobin A1c Control for Patients With Diabetes—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)** and *HbA1c Control (<8.0%)*	Hybrid
Blood Pressure Control for Patients With Diabetes	Hybrid
Eye Exam for Patients With Diabetes	Hybrid
Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years, *Ages 65 to 74 Years*, *Ages 75 to 85 Years*, and *Total*	Administrative
Controlling High Blood Pressure	Hybrid

* For this indicator, a lower rate indicates better performance.

Compliance Review

MDHHS evaluated the MHPs' compliance with federal Medicaid managed care regulations using an annual compliance review process. HSAG examined, compiled, and analyzed the results as presented in the MHP compliance review documentation provided by MDHHS. The SFY 2023 MDHHS compliance review included an evaluation of each MHP's performance in six program areas, called standards, identified in Table 3-3. These standards are reviewed annually by MDHHS in accordance with an established timeline that spans the state fiscal year. Based on the findings of the compliance review, the MHPs were subject to a corrective action plan (CAP) process as outlined in Appendix A.

Table 3-3—Compliance Review Standards[1]

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
1	Administrative	§438.224	§457.1233(e)
2	Providers	§438.10 §438.206 §438.207 §438.210 §438.214 §438.230	§457.1207 §457.1230(a) §457.1230(b) §457.1230(d) §457.1233(a) §457.1233(b)
3	Members	§438.10 §438.100 §438.114 §438.206 §438.208 §438.210 §438.228 §438.230 Part 438, Subpart F	§457.1207 §457.1220 §457.1228 §457.1230(a) §457.1230(c) §457.1230(d) §457.1260 §457.1233(b)
4	Quality	§438.208 §438.210 §438.236 §438.330	§457.1230(c) §457.1230(d) §457.1233(c) §457.1240(b)
5	MIS [Management Information System]/Financial	§438.56 §438.242	§457.1212 §457.1233(d)
6	OIG [Office of Inspector General]/Program Integrity	§438.230 Part 438, Subpart H	§457.1233(b) §457.1285

[1] HSAG and MDHHS created a crosswalk to compare MDHHS compliance review standards to federal standards, but this crosswalk should not be interpreted to mean the State's standards include all specific federal requirements under 42 CFR §438.358(b)(1)(iii).

Network Adequacy Validation

HSAG completed a network validation survey (NVS) among PCPs, pediatric providers, and OB/GYN providers contracted with one or more MHP to ensure members have appropriate access to provider information. The NVS included a provider directory validation (PDV) in which HSAG compared key indicators published in each online provider directory with the data in the MHP's provider file to confirm whether each MHP's website met the federal requirements in 42 CFR §438.10(h) and the Medicaid Care Management Services Contract, Amendment #6 requirements in §4.4.1.5. HSAG then validated the accuracy of the online provider directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories. The secret shopper survey also provided information on appointment availability and wait times with the sampled providers for routine visits. HSAG used an MDHHS-approved methodology and script to conduct the secret shopper telephone surveys of provider offices. The secret shopper approach allows for objective data collection from healthcare providers without potential bias introduced by revealing the surveyors' identities. Specific survey objectives included the following:

- Determine whether service locations accept patients enrolled with the requested MHP for the Medicaid program and the degree to which MHP and Medicaid acceptance aligns with the MHPs' provider data.
- Determine whether service locations accepting Medicaid for the requested MHP accept new patients and the degree to which new patient acceptance aligns with the MHPs' provider data.
- Determine appointment availability with the sampled provider service locations for PCP, pediatric, or OB/GYN visits.

Several limitations and analytic considerations must be noted when reviewing the NVS results. These limitations are located in Appendix A. External Quality Review Activity Methodologies.

Encounter Data Validation

In SFY 2023, HSAG conducted and completed EDV activities for all nine MHPs in accordance with CMS EQR Protocol 5. The EDV activities included:

- IS review—assessment of MDHHS' and the MHPs' IS and processes. The goal of this activity was to examine the extent to which MDHHS' and the MHPs' IS infrastructures are likely to collect and process complete and accurate encounter data.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity was to evaluate the extent to which the encounter data in MDHHS' data warehouse are complete, accurate, and submitted by the MHPs in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022.

Consumer Assessment of Healthcare Providers and Systems Analysis

The CAHPS surveys ask adult members and parents/caretakers of child members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The MHPs were responsible for obtaining a CAHPS vendor to administer the CAHPS survey for the adult Medicaid population. HSAG administered the CAHPS surveys to the child Medicaid population enrolled in the MHPs, child members enrolled in CSHCS, and adult members enrolled in HMP. HSAG presents top-box scores, which indicate the percentage of adult members or parents/caretakers of child members who responded to the survey with positive experiences in a particular aspect of their healthcare. Table 3-4 outlines an overview of the populations and survey types used for each of the applicable programs.

Table 3-4—CAHPS Surveys

Program	Population	Survey Type
Adult and Child Medicaid	Adult Medicaid and parents/caretakers of child Medicaid members enrolled in the MHPs	Adult and Child Medicaid Health Plan Surveys
CSHCS	Parents/caretakers of child members enrolled in the CSHCS Program	Modified version of the CAHPS Child Medicaid Health Plan Survey with the children with chronic conditions (CCC) measurement set
HMP	Adult members enrolled in the HMP health plans	Adult Medicaid Health Plan Survey

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide.

External Quality Review Activity Results

Aetna Better Health of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2023 evaluated the technical methods of **Aetna Better Health of Michigan**'s PIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG determined the overall methodological validity of the PIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-5 displays the overall validation rating, the baseline rate, Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-5—Overall Validation Rating for AET

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities in Timeliness of Prenatal Care	*Met*	1. Timeliness of prenatal care in rural designated ZIP Codes.	47.5%	58.6% ⇔		No
		2. Timeliness of prenatal care in urban designated ZIP Codes.	63.9%	61.7% ⇔		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MHP conducted accurate data analysis and interpretation of PIP results; overall confidence that the PIP produced significant evidence of improvement).

The goals of **Aetna Better Health of Michigan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (rural population) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (urban population) or achieve clinically or programmatically significant improvement as the result of an intervention. Table 3-6 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-6—Remeasurement 1 Barriers and Interventions for AET

Barriers	Interventions
Limited culturally relevant health literacy education regarding self-advocacy, healthy food choices, transportation, and PN/PP [prenatal/postpartum] care education. Minimal efforts have been done in the healthcare system to diversify education and expand culturally competent educational materials.	Racial and culturally concordant mailings and text message campaigns were deployed to pregnant mothers that include QR [quick response] codes on the mailings and links in the text messages to take members to "Every Mother Counts: Choices in Childbirth" resources and videos on the importance of advocating for themselves during appointments, asking questions at every visit, and that mothers have the right to make informed choices in their pregnancy, birth, and as a parent with physicians.
Lack of innovative, technological interventions to impact prenatal care rates. Leveraging mailings, text campaigns, incentives, and live outreach calls year over year is not impacting outcomes as expected.	Execution of contract with Health Intelligence Platform to offer pregnant members solutions to improve their quality of care and engagement in the healthcare system. The Health Intelligence platform will allow pregnant women access to the Baby Smart coaching program that supports appointment and transportation scheduling, pregnancy and parenting education, pregnancy monitoring and postpartum health goals, quick connections to any needed critical resources for social risks/SDOH as well as virtual doula pairing for high-risk pregnant women.
Access to timely prenatal care in rural areas.	Provider Services Team members are making strides to improve the network by attracting and retaining obstetrical healthcare providers specializing in prenatal care. Increasing the number of credentialed obstetrical provider types in rural-designated ZIP Codes is critical to achieving and maintaining improved prenatal healthcare outcomes and for women to get timelier prenatal care.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Aetna Better Health of Michigan demonstrated programmatically significant improvement over the baseline performance for the disparate population through the initiation of an intervention strategy. The intervention increased the number of credentialed obstetrical providers providing care in rural designated ZIP Codes. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan partially achieved the state-defined goals. The existing disparity was eliminated with the first remeasurement period; however, the comparison population demonstrated a non-statistically significant decline in performance as compared to the baseline. [**Quality**, **Access**, and **Timeliness**]

Why the weakness exists: While it is unclear why the comparison population demonstrated a decline in performance, **Aetna Better Health of Michigan** has made progress in improving performance for the disparate population.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** continue efforts to maintain or improve its performance for the comparison population. The MHP should also determine if any new barriers exist that are decreasing performance for this population.

Performance Measure Validation

Performance Results

Aetna Better Health of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2022 Compliance Audit Report findings, **Aetna Better Health of Michigan** was fully compliant with all seven IS standards.

According to the auditor's review, **Aetna Better Health of Michigan** followed the NCQA HEDIS MY 2022 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-7 displays the MDHHS-selected performance measures, HEDIS MY 2021 and MY 2022 rates, MY 2021 and MY 2022 comparisons, and MY 2022 performance levels based on comparisons to national percentiles[3-2] for **Aetna Better Health of Michigan**. Additional performance measures and performance measure results for **Aetna Better Health of Michigan** can be referenced in Appendix B.

[3-2] HEDIS MY 2022 performance measure rates are compared to NCQA's Quality Compass National Medicaid Health Maintenance Organization (HMO) percentiles for HEDIS MY 2021 (referred to as "percentiles" throughout this section of the report).

Table 3-7—HEDIS MY 2022 Performance Measure Results for AET

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	41.30%	46.55%	+5.25+	★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	41.89%	52.30%	+10.41+	★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	52.37%	52.67%	+0.30	★★
Ages 12 to 17 Years	44.76%	43.72%	-1.04	★
Ages 18 to 21 Years	24.29%	24.46%	+0.17	★★
Total	44.00%	44.17%	+0.17	★★
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	65.21%	65.99%	+0.78	★★★★
Ages 21 to 24 Years	65.67%	67.43%	+1.76	★★★★
Total	65.46%	66.78%	+1.32	★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	46.47%	47.69%	+1.22	★
Breast Cancer Screening				
Breast Cancer Screening	46.79%	47.70%	+0.91	★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)**	41.36%	37.96%	-3.40	★★★
HbA1c Control (<8.0%)	50.12%	52.55%	+2.43	★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	51.58%	54.26%	+2.68	★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	51.34%	59.12%	+7.78+	★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	20.01%	23.13%	+3.12+	★
Ages 65 to 74 Years	23.71%	28.85%	+5.14+	★★
Ages 75 to 85 Years	23.35%	25.00%	+1.65	★
Total	20.82%	24.11%	+3.29+	★

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Controlling High Blood Pressure				
Controlling High Blood Pressure	60.10%	57.91%	-2.19	★★

[1] HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2] Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan's performance ranked between the 75th and 89th percentile for all *Chlamydia Screening in Women* measure indicators, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-3] [**Quality**]

Strength #2: Aetna Better Health of Michigan demonstrated overall strength in its HEDIS data reporting, as **Aetna Better Health of Michigan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan's performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, ranked below the 25th percentile, indicating children who turned 15 months old during the

[3-3] National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Mar 7, 2024.

measurement year were not always having at least six well-child visits with a PCP during their first 15 months of life. Additionally, children who turned 30 months old during the measurement year were not always having at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence the health and development of a child, and they are a critical opportunity for screening and counseling.[3-4] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While the rates for both *Well-Child Visits in the First 30 Months of Life* measure indicators demonstrated significant improvement from MY 2021 to MY 2022, both rates ranked below the 25th percentile. Some barriers noted by **Aetna Better Health of Michigan** included not receiving all claim or encounter information from service providers, parents not adhering to scheduling six visits prior to 15 months of age, single mothers with multiple children only being allowed to schedule two children for well visits at a time, frequent utilization of emergency department or urgent care for non-emergency medical services by parents, transportation issues, and missed opportunities by PCPs to complete well-child visits when children are in the office for sick visits.

Recommendation: While **Aetna Better Health of Michigan** noted several interventions currently in place to target improvement, such as increased member outreach, member incentives, local community partnerships, in-home service providers, ongoing internal work group meetings, and provider incentives, performance remains low for both *Well-Child Visits in the First 30 Months of Life* measure indicators. Therefore, HSAG recommends that **Aetna Better Health of Michigan** continue its efforts to improve performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **Aetna Better Health of Michigan** could consider sharing best practices with PCPs on proper billing.

Weakness #2: Aetna Better Health of Michigan's performance for the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years*, *Ages 18 to 21 Years*, and *Total* measure indicators ranked between the 25th and 49th percentile, and below the 25th percentile for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator, indicating some children were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-5] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, Ages 18 to 21 Years,* and *Total* measure indicators ranked between the 25th and 49th percentile, and below the 25th percentile for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator. Some barriers noted by **Aetna Better Health of Michigan** included single mothers with multiple children only being allowed to schedule two children for well visits at a time, missed opportunities by PCPs to complete well-child visits when children are in the office for sick visits, frequent utilization of emergency department or urgent care for non-emergency medical services by parents, and transportation issues.

[3-4] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.
[3-5] Ibid.

Recommendation: While **Aetna Better Health of Michigan** noted several interventions currently in place to target improvement, such as increased member outreach, ongoing internal work group meetings, and provider incentives, performance remains low for all *Child and Adolescent Well-Care Visits* measure indicators. Therefore, HSAG recommends that **Aetna Better Health of Michigan** continue its efforts to improve performance for the *Child and Adolescent Well-Care Visits* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #3: Aetna Better Health of Michigan's performance for the *Cervical Cancer Screening* measure ranked below the 25th percentile, indicating women were not always being screened for cervical cancer during the specified time frame. Cervical cancer is one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-6] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Cervical Cancer Screening* measure ranked below the 25th percentile. Some barriers noted by **Aetna Better Health of Michigan** included inaccurate contact information for members, appointment availability, a high rate of no-show appointments, and transportation issues.

Recommendation: While **Aetna Better Health of Michigan** noted several interventions currently in place to target improvement, such as member incentives, partnerships with health organizations to increase member engagement, and increased mailings and outreach to members, performance remains low for the *Cervical Cancer Screening* measure. Therefore, HSAG recommends that **Aetna Better Health of Michigan** continue its efforts to improve performance for the *Cervical Cancer Screening* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **Aetna Better Health of Michigan** could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.

Weakness #4: Aetna Better Health of Michigan's performance for the *Breast Cancer Screening* measure ranked between the 25th and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[3-7] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Breast Cancer Screening* measure ranked between the 25th and 49th percentile. Some barriers noted by **Aetna Better Health of Michigan** included inaccurate contact information for members, appointment availability, a high rate of no-show appointments, and transportation issues.

Recommendation: While **Aetna Better Health of Michigan** noted several interventions currently in place to target improvement, such as mobile mammogram events, member incentives,

3-6 National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Mar 7, 2024.

3-7 National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Mar 7, 2024.

partnerships with health organization to increase member engagement, and as increased mailings and outreach to members, performance remains low for the *Breast Cancer Screening* measure. Therefore, HSAG recommends that **Aetna Better Health of Michigan** continue its efforts to improve performance for the *Breast Cancer Screening* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **Aetna Better Health of Michigan** could consider the development and deployment of a digital notification system for members needing breast cancer screening and incorporating screening reminders into current care coordination member touchpoints.

Weakness #5: Aetna Better Health of Michigan's performance for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked below the 25th percentile, except measure indicator *Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years*, which ranked between the 25th and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-8] [**Quality** and **Access**]

Why the weakness exists: The rates for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked below the 25th percentile, with the exception of one indicator which ranked between the 25th and 49th percentile. Some barriers noted by **Aetna Better Health of Michigan** included inaccurate member contact information, limited availability of weekend or evening physician appointments, frequent utilization of emergency department or urgent care for non-emergency medical services, and providers completing partial urine labs.

Recommendation: While **Aetna Better Health of Michigan** noted several interventions currently in place to target improvement, such as provider education on appropriate billing practices and routine medical record review to address identified gaps in care, performance remains low for the *Kidney Health Evaluation for Patients With Diabetes* measure. Therefore, HSAG recommends that **Aetna Better Health of Michigan** continue its efforts to improve performance for the *Kidney Health Evaluation for Patients With Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

[3-8] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Mar 7, 2024.

Compliance Review

Performance Results

Table 3-8 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-8 also presents **Aetna Better Health of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Aetna Better Health of Michigan** was subject to a corrective action review process outlined in Appendix A.

Table 3-8—Compliance Review Results for AET

Standard		Number of Scores			Compliance Scores	
		Met	*Satisfied*[1]	*Not Met*	AET[2]	Statewide[3]
1	Administrative	5	0	0	100%	100%
2	Providers	22	0	1	96%	94.7%
3	Members	29	0	0	100%	97.7%
4	Quality	21	0	1	95%	99.5%
5	MIS/Financial	38	1	1	95%	96.1%
6	OIG/Program Integrity	34	0	1	97%	90.2%
Overall		**149**	**1**	**4**	**97%**	**95.5%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

[2] MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

[3] MDHHS calculated statewide performance scores to the tenth decimal place; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **Aetna Better Health of Michigan** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Aetna Better Health of Michigan achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: While **Aetna Better Health of Michigan** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Quality standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *4.9 Performance Monitoring Report (PMR) Review and Response*. [**Quality**]

Why the weakness exists: Aetna Better Health of Michigan did not provide an improvement plan for the *Comprehensive Diabetes Care: Preventive Dental Visit* measure; and only addressed one cohort for the *Transition out of CFP* [Consistently Fail to Pay] *Status* measure when the standard was not met for additional cohorts. **Aetna Better Health of Michigan** reported that it did not have adequate review process and quality checks in place to identify each unmet measure and ensure that all unmet measures were included in the performance improvement plan.

Recommendation: Aetna Better Health of Michigan was required to submit a CAP to address element 4.9, which was approved by MDHHS. As such, HSAG recommends that **Aetna Better Health of Michigan** continue to implement action plans and monitoring processes to ensure performance improvement plans are implemented timely when minimum standards are not met.

Weakness #2: While **Aetna Better Health of Michigan** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *5.11 Claims Processing (Non-Pharmacy)* and a *Satisfied* score for element *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS* [Community Health Automated Medicaid Processing System]. [**Quality**]

Why the weakness exists: Aetna Better Health of Michigan did not meet the standard of *maintaining less than 1 percent ending inventory greater than 45 days* for two reporting months. The MHP reported that claims adjudicated for providers for whom checks had already been returned for bad addresses were pended to eliminate the financial fraud risk associated with sending checks to incorrect addresses. Claims in a pended status remained in inventory until a final disposition of the claim occurred. Additionally, **Aetna Better Health of Michigan** did not meet the 12 percent or less standard for the *percent of rejected claims* for one reporting month. The MHP reported that the clean-claim rejection rate was a reporting error and not an accurate reflection of the actual clean-

claim rejection rate due to a change in reporting logic, which has since been corrected. Further, **Aetna Better Health of Michigan** did not meet the 95 percent standard for *dental encounter transmissions loaded into CHAMPS*. The MHP reported this variance occurred due to configuration issues.

Recommendation: Aetna Better Health of Michigan had a previous CAP and was required to submit another CAP to address element 5.11, which was approved by MDHHS. However, MDHHS did not require a CAP to address element 5.15. As such, HSAG recommends that **Aetna Better Health of Michigan** continue to implement action plans and monitoring processes to ensure all claims processing performance standards are consistently met (i.e., *Maintain less than 1% of ending inventory greater than 45 days*, *Percent of rejected claims must be 12% or less*, and *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS*).

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 351 cases by comparing provider data that **Aetna Better Health of Michigan** submitted to HSAG against **Aetna Better Health of Michigan**'s online provider directory. The sample included 156 PCPs, 156 pediatric providers, and 39 OB/GYN providers (Table 3-9). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 81.5 percent (n=286) of the reviews. The sampled providers were not found in the online provider directory in 18.5 (n=65) percent of the reviewed cases.

Table 3-9—Summary of Providers Present in the Directory by Provider Category

		Providers Found in Directory		Providers Not Found in Directory	
Provider Category	Number of Sampled Providers	Count	%	Count	%
PCPs	156	128	82.1%	28	17.9%
Pediatric Providers	156	123	78.8%	33	21.2%
OB/GYN Providers	39	35	89.7%	4	10.3%
AET Total	**351**	**286**	**81.5%**	**65**	**18.5%**

Table 3-10 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Aetna Better Health of Michigan**'s provider data submission to HSAG and **Aetna Better Health of Michigan**'s online provider directory.

Table 3-10—Provider Demographic Indicators Matching Online Provider Directory

	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%	Count	%
Provider's Name	128	100%	123	100%	34	97.1%	285	99.7%
Provider Street Address	105	82.0%	94	76.4%	29	82.9%	228	79.7%
Provider Suite Number	112	87.5%	111	90.2%	34	97.1%	257	89.9%
Provider City	124	96.9%	108	87.8%	32	91.4%	264	92.3%
Provider State	128	100%	123	100%	35	100%	286	100%
Provider ZIP Code	119	93.0%	106	86.2%	31	88.6%	256	89.5%
Provider Telephone Number	121	94.5%	99	80.5%	28	80.0%	248	86.7%
Provider Type/Specialty	124	96.9%	123	100%	26	74.3%	273	95.5%
Provider Accepting New Patients	122	95.3%	121	98.4%	32	91.4%	275	96.2%
Provider Gender	128	100%	123	100%	34	97.1%	285	99.7%
Provider Primary Language*	128	100%	123	100%	35	100%	286	100%
Non-English Language Speaking Provider (including American Sign Language)*	128	100%	109	88.6%	30	85.7%	267	93.4%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 227 sampled provider locations (i.e., "cases") for **Aetna Better Health of Michigan**, with an overall response rate of 72.7 percent (n=165). Table 3-11 summarizes the secret shopper survey results for **Aetna Better Health of Michigan**.

Table 3-11—Summary of AET Secret Shopper Survey Results

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
PCPs	111	75	67.6%	47	62.7%	41	54.7%	39	52.0%	36	48.0%
Pediatric Providers	95	78	82.1%	38	48.7%	33	42.3%	32	41.0%	29	37.2%
OB/GYN Providers	21	12	57.1%	5	41.7%	3	25.0%	3	25.0%	1	8.3%
AET Total	**227**	**165**	**72.7%**	**90**	**54.5%**	**77**	**46.7%**	**74**	**44.8%**	**66**	**40.0%**

Table 3-12 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Aetna Better Health of Michigan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-12—Appointment Availability Results

			Cases Offered an Appointment			Appointment Wait Time (Days)				
Provider Category	Total Survey Cases	Cases Accepting New Patients	Count	Rate Among All Surveyed Cases[1] (%)	Rate Among Cases Accepting New Patients[2] (%)	Min	Max	Average	Median	Percentage of Cases Within Standard[3]
PCPs	111	35	14	12.6%	40.0%	1	117	20	7	78.6%
Pediatric Providers	95	27	9	9.5%	33.3%	1	7	2	1	100%
OB/GYN Providers	21	1	1	4.8%	100%	5	5	5	5	100%
AET Total	**227**	**63**	**24**	**10.6%**	**38.1%**	**1**	**117**	**13**	**5**	**87.5%**

[1] The denominator includes all surveyed cases included in the sample.
[2] The denominator includes cases responding to the survey that accept the insurance and new patients.
[3] The denominator includes cases offered an appointment. The MDHHS appointment timeliness standards are 30 business days for routine care appointments and seven business days for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the providers that reviewers located in **Aetna Better Health of Michigan**'s online provider directory, eight of 12 indicators had a match rate above 90 percent. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Reviewers located only 81.5 percent of the sampled providers in **Aetna Better Health of Michigan**'s online provider directory. Among the provider categories, 21.2 percent of pediatric providers, 17.9 percent of PCP providers, and 10.3 percent of OB/GYN providers could not be located in the online directory. **[Access]**

Why the weakness exists: While **Aetna Better Health of Michigan** submitted provider data to HSAG, the providers listed in the data were not confirmed within the **Aetna Better Health of Michigan** online provider directory. The mismatch indicates inaccurate provider information within the provider data and/or online provider directory.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., inaccurate and/or missing provider information) to address the provider data deficiencies.

Weakness #2: Only 72.7 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **Aetna Better Health of Michigan**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #3: Of the locations reached, only 54.4 percent confirmed affiliation with the sampled provider. Additionally, 46.7 percent confirmed accuracy of the sampled address, 44.8 percent confirmed the services were offered, and 40.0 percent confirmed the requested insurance was accepted. [**Quality** and **Access**]

Why the weakness exists: **Aetna Better Health of Michigan**'s provider data included invalid provider, specialty, and insurance information.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

Weakness #4: Of the cases responding to the survey and accepting the insurance and new patients, only 38.1 percent of locations offered an appointment date. [**Access**]

Why the weakness exists: For new **Aetna Better Health of Michigan** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid identification (ID), or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Aetna Better Health of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **Aetna Better Health of Michigan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Aetna Better Health of Michigan**'s original questionnaire responses, and **Aetna Better Health of Michigan** responded to these specific questions. To support its questionnaire responses, **Aetna Better Health of Michigan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Aetna Better Health of Michigan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-13 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-13—EDV Results for AET

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• For medical claims, **Aetna Better Health of Michigan** utilized QNXT, Edifecs, and Ramp Manager as its primary software for claim adjudication and encounter preparation. For dental claims, it used Code Editing (CE). • **Aetna Better Health of Michigan** had processes in place to detect and identify duplicate claims. **Aetna Better Health of Michigan** exclusively submitted complete claims and did not submit voided claims. Additionally, it indicated that denied claims were not transmitted by its vendors. In situations necessitating adjustments, it used the claim frequency code "7" to denote an adjusted encounter. • **Aetna Better Health of Michigan** and its subcontractors were responsible for collecting and maintaining provider information. Additionally, **Aetna Better Health of Michigan** managed enrollment data received from MDHHS through 834 files, providing daily Medicaid enrollment updates to the MHPs for integration into their claim processing systems. **Aetna Better Health of Michigan** ensured that subcontractors also

Analysis	Key Findings
	received and incorporated these enrollment details into their respective claim systems.
Payment Structures	• **Aetna Better Health of Michigan** used the percent billed and Diagnosis-Related Group (DRG) methods for its claim payment strategies for inpatient encounters. For outpatient and pharmacy encounters, it utilized line-by-line and ingredient cost methods, respectively. • In general, **Aetna Better Health of Michigan** processed claims with third party liability (TPL) based on the collected insurance coverage information. When a claim suggests the existence of additional primary insurance for a member, the MHP's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details.
Encounter Data Quality Monitoring	• **Aetna Better Health of Michigan** and/or its subcontractors performed several data quality checks on the encounter data collected. These checks included, but were not limited to, analyzing claim volume by submission month (for laboratory and pharmacy), assessing field-level completeness and validity (for all subcontractor encounters, including dental, laboratory, non-emergency medical transportation [NEMT], pharmacy, and vision), evaluating timeliness (for all subcontractor encounters except pharmacy), and ensuring alignment between payment fields in claims and financial reports (specifically for pharmacy). • For encounters collected by **Aetna Better Health of Michigan**, it only conducted data quality checks by evaluating whether the payment fields in the claims align with the financial reports.
Administrative Profile	
Encounter Data Completeness	• **Aetna Better Health of Michigan** displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • **Aetna Better Health of Michigan** had a low volume of duplicate encounters, with 0.1 percent of professional encounters, less than 0.1 percent of institutional encounters, 0.2 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative.
Encounter Data Timeliness	• **Aetna Better Health of Michigan** demonstrated timely submission of professional, institutional, dental, and pharmacy encounters. Within 60 days, **Aetna Better Health of Michigan** submitted 99.0 percent of professional encounters to MDHHS

Analysis	Key Findings
	after the payment date, and within 90 days, submitted 99.0 percent of institutional encounters to MDHHS after the payment date. • Within 30 days, **Aetna Better Health of Michigan** submitted 99.8 percent of dental encounters and 99.9 percent of pharmacy encounters to MDHHS after the payment date. • **Aetna Better Health of Michigan**'s submitted data contained a missing paid or submission date for less than 0.1 percent of pharmacy encounters.
Field-Level Completeness and Accuracy	• All data elements in **Aetna Better Health of Michigan**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs (unique member identifier) in **Aetna Better Health of Michigan**'s submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the enrollment data. • Of all identified member IDs in **Aetna Better Health of Michigan**'s submitted pharmacy data, 99.8 percent were identified in the enrollment data. • Of all identified provider NPIs (National Provider Identifier) in **Aetna Better Health of Michigan**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. • Of all identified provider NPIs in **Aetna Better Health of Michigan**'s submitted pharmacy encounter data, 97.1 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Aetna Better Health of Michigan**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The MHP also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Aetna Better Health of Michigan submitted professional, institutional, dental, and pharmacy encounters in a timely manner from the payment date, with about 98 percent of all encounters submitted within 30 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all categories of service, key data elements for **Aetna Better Health of Michigan** were populated at high rates and generally greater than 95 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan reported only conducting one quality check for claims/encounters stored in its data warehouses. [**Quality**]

Why the weakness exists: Only the reconciliation with the financial report was listed as being conducted, and no other checks for accuracy, completeness, or timeliness were mentioned.

Recommendation: Aetna Better Health of Michigan should build a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness for encounters collected by **Aetna Better Health of Michigan**.

Weakness #2: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 97 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: Aetna Better Health of Michigan should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-14 presents **Aetna Better Health of Michigan**'s 2022 and 2023 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-14—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for AET

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Global Ratings				
Rating of Health Plan	65.31%	57.89%	64.80%	66.67%
Rating of All Health Care	51.61%	54.19%	63.38%+	67.54%
Rating of Personal Doctor	67.74%	68.00%	72.45%+	74.72%
Rating of Specialist Seen Most Often	66.25%+	64.66%	80.00%+	65.96%+
Composite Measures				
Getting Needed Care	83.36%	83.11%	88.31%+	82.12%+
Getting Care Quickly	84.43%+	77.26%	88.73%+	85.03%+
How Well Doctors Communicate	92.74%	91.04%	91.79%+	92.23%
Customer Service	89.86%+	89.65%	85.19%+	90.04%+
Individual Item Measure				
Coordination of Care	79.71%+	84.43%	88.46%+	83.02%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	72.37%	70.86%	—	—
Discussing Cessation Medications	57.89%	54.34%	—	—
Discussing Cessation Strategies	50.34%	51.20%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA adult and child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult and child Medicaid national averages or 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—CSHCS

Table 3-15 presents **Aetna Better Health of Michigan**'s 2022 and 2023 CSHCS CAHPS top-box scores. The following measures could not be displayed in the table because these measures had fewer than 11 responses and were suppressed: *Rating of Children's Multidisciplinary Specialty (CMDS) Clinic*, *Customer Service*, *Access to Specialized Services*, *Transportation*, *CMDS Clinic*, and *Local Health Department Services*. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-15—Summary of CSHCS CAHPS Survey Top-Box Scores for AET

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	58.33%$^{+}$	81.25%$^{+}$
Rating of Health Care	69.23%$^{+}$	88.89%$^{+}$ NA
Rating of Specialist Seen Most Often	—	85.71%$^{+}$
Composite Measures		
How Well Doctors Communicate	95.45%$^{+}$	96.15%$^{+}$ NA

	2022 Top-Box Score	2023 Top-Box Score
Individual Item Measures		
Access to Prescription Medicines	—	100%+ ↑
Not Felt Treated Unfairly: Race and Ethnicity	81.82%+	92.31%+ NA
Not Felt Treated Unfairly: Health Insurance Type	81.82%+	100%+ NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
NA indicates a national average is not available for the measure.
— Indicates results were suppressed due to having fewer than 11 respondents.

Strengths, Weaknesses, and Recommendations—CSHCS

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, *Access to Prescription Medicines.* [**Access**].

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-16 presents **Aetna Better Health of Michigan**'s 2022 and 2023 HMP CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-16—Summary of HMP CAHPS Top-Box Scores for AET

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	56.44%	59.68%
Rating of All Health Care	50.94%+	57.38%+
Rating of Personal Doctor	61.90%+	62.65%+
Rating of Specialist Seen Most Often	58.97%+	62.22%+
Composite Measures		
Getting Needed Care	83.09%+	87.97%+
Getting Care Quickly	84.19%+	76.33%+
How Well Doctors Communicate	92.22%+	92.80%+
Customer Service	80.56%+	90.22%+
Individual Item Measure		
Coordination of Care	79.17%+	89.29%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	81.48%+	77.22%+
Discussing Cessation Medications	58.02%+	51.90%+
Discussing Cessation Strategies	43.75%+	50.00%+

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.

Strengths, Weaknesses, and Recommendations—HMP

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Aetna Better Health of Michigan's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Aetna Better Health of Michigan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Aetna Better Health of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide, which is inclusive of **Aetna Better Health of Michigan**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **Aetna Better Health of Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Aetna Better Health of Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Aetna Better Health of Michigan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-17 displays each applicable performance area and the overall performance impact related to the quality, timeliness, and accessibility of healthcare services provided to **Aetna Better Health of Michigan**'s Medicaid members.

Table 3-17—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access**—**Aetna Better Health of Michigan** continued its MDHHS-mandated PIP focused on disparities in timeliness of prenatal care between its rural population and urban population. Through **Aetna Better Health of Michigan**'s implemented interventions, the existing disparity was eliminated during the first remeasurement period with the rate of members in rural areas receiving timely prenatal care, increasing by 11.1 percentage points over the baseline rate of 47.5 percent. **Aetna Better Health of Michigan** also appropriately implemented an intervention specific to the disparate population (rural population) and increased the number of

Performance Area	Overall Performance Impact
	credentialed OB/GYN providers providing care in rural designated ZIP Codes. The increase in the number of providers likely resulted in additional members living in rural areas being able to obtain timely prenatal care, suggesting **Aetna Better Health of Michigan**'s implementation of its PIP contributed to positive health outcomes for moms and babies. Additionally, **Aetna Better Health of Michigan** met MDHHS' expectations for addressing health disparities through population health management as demonstrated by a 95 percent compliance score for the Quality standard; and specifically, a *Met* score for element *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*, demonstrating that it had adequate policies and procedures for providing population health management services. **Aetna Better Health of Michigan** should continue to conduct data analysis through its quality program to identify and subsequently implement interventions to reduce disparities in health care. However, while not statistically significant, the comparison population of **Aetna Better Health of Michigan**'s PIP, members residing in urban areas, demonstrated a rate decline to 61.7 percent compared to the baseline rate of 63.9 percent. Opportunities for improving the timeliness of prenatal care is also supported by the results of the HEDIS audit documented within the 2023 HEDIS Aggregate Report for Michigan Medicaid located in Appendix B. The rate for the *Timeliness of Prenatal Care* measure decreased by 5.59 percentage points compared to the prior year and ranked below the 25th Medicaid Quality Compass percentile. Prenatal care during the first trimester can lower the risk of pregnancy complications. **Aetna Better Health of Michigan** should explore what may be driving down this performance and consider if its members residing in urban areas may be experiencing additional barriers or if other disparities exist within the data (i.e., race/ethnicity) that should be targeted for improvement. Further, the results of the NAV activity indicate that some of **Aetna Better Health of Michigan**'s members may be experiencing challenges contacting or scheduling appointments with OB/GYN providers due to invalid information within the provider directory, including provider telephone or address, provider type/specialty, provider accepting new patients, and/or provider accepting insurance information. **Aetna Better Health of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members to further ensure members are able to obtain timely prenatal care.
Preventive Care	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity confirmed several opportunities for **Aetna Better Health of Michigan** to continue to improve access to preventive care. Although there was improvement noted in most of these measures from the prior year, all rates for the *Well-Child Visits in the First 30 Months of Life*, *Child and Adolescent Well-Care Visits*, *Cervical Cancer Screening*, and *Breast Cancer Screening* ranked either below

Performance Area	Overall Performance Impact
	the 25th Medicaid Quality Compass percentile or between the 25th and 49th percentile. Preventive care and screenings can monitor growth and development, reduce the chance of obtaining a vaccine preventable condition, and lead to early detection of cancer. Additionally, the results of the NAV activity indicate that some of **Aetna Better Health of Michigan**'s members may be experiencing challenges making appointments with PCPs or pediatric providers due to inaccurate information within **Aetna Better Health of Michigan**'s provider directory, and provider offices informing members that they do not accept **Aetna Better Health of Michigan** Medicaid insurance. Further, of providers responding to the survey and accepting the insurance and new patients, only 40 percent and 33.3 percent of PCPs and pediatric providers, respectively, offered an appointment; and while all pediatric providers who offered a routine appointment offered the appointment timely, only 78.6 percent of PCPs who offered an appointment met MDHHS' appointment timeliness standard of 30 business days. **Aetna Better Health of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged from 62.65 percent to 74.72 percent. **Aetna Better Health of Michigan** should also consider these results when determining potential barriers for members accessing preventive care due to dissatisfaction with their PCP. However, **Aetna Better Health of Michigan** also demonstrated strengths related to preventive care as all rates for the *Chlamydia Screening in Women* measure ranked between the 75th and 89th Medicaid Quality Compass percentile and demonstrated slight improvement from the prior year. Screenings can lead to early treatment of chlamydia and reduce the occurrence of serious complications. Additionally, while **Aetna Better Health of Michigan** performed poorly overall for the *Well-Child Visits in the First 30 Months of Life* measure, it should be noted that both rates demonstrated a statistically significant improvement from the prior year, indicating more of the MHP's members received timely well-child visits for age-appropriate assessments, screenings, and counseling. **Aetna Better Health of Michigan** should continue its initiatives that were developed and subsequently proven successful at improving performance in this program area. Further, as demonstrated through the compliance review, **Aetna Better Health of Michigan** met MDHHS' expectations for monitoring appointment wait times for preventive services. Specifically, **Aetna Better Health of**

Performance Area	Overall Performance Impact
	Michigan received a *Met* score for element *2.10 Provider Wait Times* under the Providers standard, which included but was not limited to monitoring of the following metrics: *Routine Care is available within 30 Business Days of request*, *Routine Dental Care is within 21 Business Days of request*, and *Preventive Dental Services is within six weeks of request*.
Care for Chronic Conditions	**Quality**, **Timeliness**, and **Access**—Overall, **Aetna Better Health of Michigan** demonstrated mostly mixed results across the EQR activities pertaining to chronic conditions. The PMV activity results confirmed that **Aetna Better Health of Michigan** ranked between the 50th and 74th Medicaid Quality Compass percentile for all rates for the *Hemoglobin A1c Control for Patients With Diabetes* and *Eye Exam for Patients With Diabetes* measures. **Aetna Better Health of Michigan** also demonstrated an increase in performance from the prior year for *Blood Pressure Control for Patients With Diabetes* and *Kidney Health Evaluation for Patients With Diabetes*, with statistically significant improvement for four of the five rates. Appropriate management of chronic conditions can reduce symptoms and the chance of serious complications and improve quality of life. As demonstrated by a *Met* score for element *3.10 CSHCS PCP Requirements* under the Members standard within the compliance review activity, **Aetna Better Health of Michigan** met MDHHS' expectations for assignment of PCPs for children and youth with complex chronic conditions. However, under element *4.9 Performance Monitoring Report (PMR) Review and Response* within the Quality standard, **Aetna Better Health of Michigan** did not provide MDHHS with an improvement plan for the MDHHS dental measure, *Comprehensive Diabetes Care: Preventive Dental Visit*, which is required when the standard for a measure is not met. According to the Centers for Disease Control and Prevention (CDC), gum disease can be more severe, can take longer to heal, and be harder to manage for individuals with diabetes; therefore, regular dental appointments for routine care are important to prevent problems. Additionally, the results of the NAV activity indicated that some of **Aetna Better Health of Michigan**'s members may be experiencing challenges making appointments with PCPs due to inaccurate provider directory information, and PCP offices indicating that they do not accept **Aetna Better Health of Michigan** Medicaid insurance or new patients. Further, of PCP offices responding to the survey who indicated that they accepted **Aetna Better Health of Michigan** Medicaid insurance and new patients, only 40 percent offered an appointment and only 78.6 percent of those offering an appointment met the MDHHS appointment timeliness standard of 30 business days. **Aetna Better Health of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements.

Performance Area	Overall Performance Impact
	Further, while **Aetna Better Health of Michigan** demonstrated improvement for the *Blood Pressure Control for Patients With Diabetes* and *Kidney Health Evaluation for Patients With Diabetes* measures, all rates for these measures and the *Controlling High Blood Pressure* measure ranked either below the 25th Medicaid Quality Compass percentile or between the 25th and 49th percentile. **Aetna Better Health of Michigan** should continue efforts in identifying interventions to mitigate barriers to care and ensure its members' chronic conditions are appropriately managed. Unmanaged chronic conditions lead to poor member outcomes and increased healthcare costs. Lastly, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged from 62.65 percent to 74.72 percent. **Aetna Better Health of Michigan** should also consider these results when determining potential barriers for members accessing care for chronic conditions due to dissatisfaction with their PCP.
Health Information Systems and Technology	**Quality**, **Timeliness**, and **Access—Aetna Better Health of Michigan** demonstrated strengths of its health information systems and technology through the PMV, compliance, and EDV activities. The PMV findings confirmed that **Aetna Better Health of Michigan** was fully compliant with how it collected, stored, analyzed, and reported HEDIS data. All rates were *Reportable*, indicating that **Aetna Better Health of Michigan** followed the NCQA technical specifications for the calculation of HEDIS performance measures. Additionally, although **Aetna Better Health of Michigan** scored below the statewide average for the MIS/Financial standard within the compliance review activity, it received a score of 95 percent, indicating that it met MDHHS' expectations for most requirements pertaining to **Aetna Better Health of Michigan**'s MIS. Further, through the EDV activity, **Aetna Better Health of Michigan** demonstrated its capability to collect, process, and transmit encounter data to MDHHS; submit encounter data timely; and populate valid key data elements for all service categories. However, as **Aetna Better Health of Michigan** only reported one quality check for claims and encounters via reconciliation with financial reports as indicated through the EDV, it should consider additional monitoring reports to further evaluate encounter data accuracy, completeness, and timeliness for encounters. Additionally, as less pharmacy provider NPIs were identified in provider data than medical and dental provider NPIs, **Aetna Better Health of Michigan** should also collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers. Lastly, as demonstrated through the compliance review findings, **Aetna Better Health of Michigan** was not fully compliant with the *Maintain less than 1% of ending inventory greater than 45 days*, *Percent of rejected claims must be*

Performance Area	Overall Performance Impact
	12% or less, and *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS* (related to dental invoice types) metrics under compliance review elements *5.11 Claims Processing (Non-Pharmacy)* and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. Therefore, **Aetna Better Health of Michigan** should continue to implement action plans and monitoring processes to ensure all claims processing performance standards are consistently met.

Blue Cross Complete of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2023 evaluated the technical methods of **Blue Cross Complete of Michigan**'s PIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG determined the overall methodological validity of the PIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-18 displays the overall validation rating, the baseline rate, Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-18—Overall Validation Rating for BCC

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Reducing Racial Disparities Within Timeliness of Prenatal Care	*Met*	1. Black women residing in Region 10 (disparate group)	66.98%	67.05% ⇔		Yes
		2. White women residing in Region 10 (comparison group)	76.61%	73.66% ⇔		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MHP conducted accurate data analysis and interpretation of PIP results; overall confidence that the PIP produced significant evidence of improvement.).

The goals for **Blue Cross Complete of Michigan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-19 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-19—Remeasurement 1 Barriers and Interventions for BCC

Barriers	Interventions
Late entry into prenatal care for Black women—many Black women receive prenatal care outside the HEDIS time frame of within the first trimester or within 42 days of enrolling into the health plan.	Stratify pregnant Black women in Wayne County/Region 10 as high risk for priority high touch early outreach by Bright Start and expedited referral to a home visiting MIHP.
Unable to reach (UTR) women by phone—barrier for members for whom the plan has no active phone number or for whom there is no response to outreach.	Establish handoff process for UTR prioritized members from Bright Start to Community Outreach team for expedited door-to-door follow-up.
Structural racism/lack of safe spaces and ability to safely trust in the healthcare system—Black women do not feel they can safely receive information and care from the healthcare system.	Establish a safe space for pregnant Black women to get trusted peer-led education about prenatal care by developing Community Pregnancy Groups in Detroit.
Need for education about the importance of timely prenatal care—women are not aware of the importance of a prenatal care visit within the first trimester.	Launch Facebook/Instagram social media campaign with prenatal messaging for focus population of Black women of childbearing age in Detroit.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Blue Cross Complete of Michigan initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Blue Cross Complete of Michigan demonstrated both clinically and programmatically significant improvement over the baseline performance for the disparate population through the initiation of an intervention strategy. The intervention strategy demonstrating clinically significant improvement stratified all Black women as high-risk and prioritized them to receive outreach by a nurse case manager. The intervention strategy demonstrating programmatically significant improvement launched a peer-led pregnancy group where Black women can receive pregnancy-related education. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Blue Cross Complete of Michigan did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period, and the comparison group

demonstrated a non-statistically significant decrease in performance as compared to the baseline. [**Quality**, **Access,** and **Timeliness**]

Why the weakness exists: While it is unclear why the goal was not achieved or why the comparison population declined in performance, **Blue Cross Complete of Michigan** has made progress in improving performance for the disparate population.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance.

Performance Measure Validation

Performance Results

Blue Cross Complete of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2022 Compliance Audit Report findings, **Blue Cross Complete of Michigan** was fully compliant with all seven IS standards.

According to the auditor's review, **Blue Cross Complete of Michigan** followed the NCQA HEDIS MY 2022 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-20 displays the MDHHS-selected performance measures, HEDIS MY 2021 and MY 2022 rates, MY 2021 and MY 2022 comparisons, and MY 2022 performance levels based on comparisons to national percentiles[3-9] for **Blue Cross Complete of Michigan**. Additional performance measures and performance measure results for **Blue Cross Complete of Michigan** can be referenced in Appendix B.

Table 3-20—HEDIS MY 2022 Performance Measure Results for BCC

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.80%	67.72%	+5.92+	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	62.98%	63.64%	+0.66	★★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	59.20%	59.79%	+0.59	★★★
Ages 12 to 17 Years	49.83%	48.29%	-1.54++	★★

[3-9] HEDIS MY 2022 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2021 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Ages 18 to 21 Years	31.08%	29.30%	**-1.78++**	★★★
Total	51.22%	50.85%	-0.37	★★★
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	58.41%	60.81%	+2.40+	★★★★
Ages 21 to 24 Years	63.32%	65.78%	+2.46+	★★★
Total	61.08%	63.55%	+2.47+	★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	59.49%	60.30%	+0.81	★★★
Breast Cancer Screening				
Breast Cancer Screening	52.25%	53.29%	+1.04	★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)**	37.96%	34.06%	-3.90	★★★★
HbA1c Control (<8.0%)	50.85%	59.61%	+8.76+	★★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	54.99%	54.01%	-0.98	★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	59.37%	70.07%	+10.70+	★★★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	28.07%	34.76%	+6.69+	★★★
Ages 65 to 74 Years	29.59%	40.39%	+10.80+	★★★
Ages 75 to 85 Years	25.53%	37.93%	+12.40	★★★
Total	28.08%	34.85%	+6.77+	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	57.95%	58.81%	+0.86	★★

[1] HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2] Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Blue Cross Complete of Michigan's performance ranked above the 90th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, which is a significant improvement from the prior year, indicating children who turned 15 months old during the measurement year were getting at least six well-child visits with a PCP during their first 15 months of life most of the time. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-10] [**Quality**, **Timeliness**, and **Access**]

Strength #2: Blue Cross Complete of Michigan's performance ranked between the 75th and 89th percentile for the *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Total* measure indicators, which is a significant improvement from the prior year, indicating women identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-11] [**Quality**]

Strength #3: Blue Cross Complete of Michigan's performance ranked above the 90th percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicator, which is a marked improvement from the prior year. Additionally, performance for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicator ranked between the 75th and 90th percentile, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-12] [**Quality** and **Access**]

Strength #4: Blue Cross Complete of Michigan's performance ranked between the 75th and 89th percentile for the *Blood Pressure Control for Patients With Diabetes* measure indicator, indicating members with diabetes had controlled blood pressure readings most of the time. The risk of

[3-10] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.
[3-11] National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Mar 7, 2024.
[3-12] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.

cardiovascular disease rises as systolic blood pressure increases in patients with diabetes mellitus.[3-13] [**Quality** and **Access**]

Strength #5: Blue Cross Complete of Michigan demonstrated overall strength in its HEDIS data reporting, as **Blue Cross Complete of Michigan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Blue Cross Complete of Michigan's performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator ranked between the 25th and 49th percentile, indicating some children were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-14] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator ranked between the 25th and 49th percentile, suggesting barriers exist for children to receive timely well-child visits. SDOH such as housing, education, and employment needs, can adversely impact a parent's ability to ensure timely well-care visits.[3-15]

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** conduct a root cause analysis to determine why some children did not receive timely well-child visits. **Blue Cross Complete of Michigan** could also consider working with providers to integrate appointment barrier screening into appointment reminder calls or notifications. Upon identification of a root cause, **Blue Cross Complete of Michigan** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator.

Weakness #2: Blue Cross Complete of Michigan's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentile, indicating children who turned 30 months old during the measurement year were not always having at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-16] [**Quality**, **Timeliness**, and **Access**]

[3-13] American Academy of Family Physicians. Effects of Intensive Blood Pressure Control in Patients with Diabetes Mellitus. Available at: https://www.aafp.org/pubs/afp/issues/2011/0301/p612a.html. Accessed on: Mar 7, 2024.

[3-14] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

[3-15] National Library of Medicine. Caregiver and Clinician Perspectives on Missed Well-Child Visits. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7227475/. Accessed on: Sept 25, 2023.

[3-16] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentile, suggesting that barriers exist or that current measure interventions may benefit from modification to better impact measure performance.

Recommendation: While **Blue Cross Complete of Michigan** noted several interventions currently in place to target improvement, such as facilitating telephonic and community-based member outreach, conducting member texting campaigns, utilizing social media posts, and distributing newsletters to members, performance remains low for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. Therefore, HSAG recommends that **Blue Cross Complete of Michigan** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #3: Blue Cross Complete of Michigan's performance for the *Controlling High Blood Pressure* measure ranked between the 25th and 49th percentile, indicating some members with a diagnosis of hypertension did not have controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-17] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Controlling High Blood Pressure* measure ranked between the 25th and 49th percentile, suggesting that barriers exist for members with hypertension to have controlled blood pressure.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** conduct a root cause analysis or focused study to determine why some members with hypertension did not have controlled blood pressure. Upon identification of a root cause, **Blue Cross Complete of Michigan** should implement appropriate interventions to improve the performance related to the *Controlling High Blood Pressure* measure indicator.

[3-17] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Mar 7, 2024.

Compliance Review

Performance Results

Table 3-21 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-21 also presents **Blue Cross Complete of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Blue Cross Complete of Michigan** was subject to a corrective action review process outlined in Appendix A.

Table 3-21—Compliance Review Results for BCC

Standard		Number of Scores			Compliance Scores	
		Met	*Satisfied*[1]	*Not Met*	BCC[2]	Statewide[2]
1	Administrative	5	0	0	100%	100%
2	Providers	22	0	1	96%	94.7%
3	Members	29	0	0	100%	97.7%
4	Quality	22	0	0	100%	99.5%
5	MIS/Financial	38	1	1	95%	96.1%
6	OIG/Program Integrity	30	0	5	86%	90.2%
Overall		**146**	**1**	**7**	**95%**	**95.5%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

[2] MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

[3] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **Blue Cross Complete of Michigan** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Blue Cross Complete of Michigan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Blue Cross Complete of Michigan achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Blue Cross Complete of Michigan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, clinical practice guidelines (CPGs), quality improvement project (QIP) description, work plan, and evaluation; utilization management (UM) program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: While **Blue Cross Complete of Michigan** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *5.6 Pharmacy/MCO Common Formulary* and a *Satisfied* score for element *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. [**Quality**]

Why the weakness exists: Blue Cross Complete of Michigan did not achieve the threshold of less than 0.1 percent of noncompliant National Council for Prescription Drug Programs (NCPDP) 70 rejected claims. The MHP identified several issues that were caused by either a code that was incorrectly removed due to human error; a code that was added and resulted in an unexpected error code; or a conflict that occurred due to underlying coding that triggered an inappropriate NCPDP 70 error. Additionally, **Blue Cross Complete of Michigan** did not meet the minimum 95 percent encounter acceptance rate for dental invoice types for one reporting month due to duplication rejections, and the MHP reported working to update encounter submissions to exclude duplications.

Recommendation: Blue Cross Complete of Michigan was required to submit a CAP to address element 5.6, which was approved by MDHHS. However, MDHHS did not require a CAP to address element 5.15. As such, HSAG recommends that **Blue Cross Complete of Michigan** continue to implement action plans and monitoring processes to ensure all claims processing performance standards are consistently met (i.e., *Accurate NCPDP 70 Rejections*, *Must have less than 0.1% noncompliant claims for products covered on the Common Formulary,* and *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS*).

Weakness #2: Blue Cross Complete of Michigan demonstrated moderate performance overall (i.e., 80 percent or higher but less than 90 percent) in the OIG/Program Integrity standard and scored

below the statewide average. The MHP received a *Not Met* score for elements *6.1 Quarterly Program Integrity Forms – Tips and Grievances – FY22 Q4*, *6.2 Quarterly Program Integrity Forms – Data Mining – FY22 Q1*, *6.3 Quarterly Program Integrity Forms – Audits – FY22 Q1*, *6.8 Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY22 Q1*, and *6.8 Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY22 Q2*. [**Quality**]

Why the weakness exists: MDHHS identified multiple data errors across several reporting forms. **Blue Cross Complete of Michigan** reported the changes to the program integrity reporting template and guidance document were communicated to the area that manages the report and the various business owners who provide data and other information used to generate the report. However, errors occurred because the necessary changes were not initially incorporated by some departments responsible for data/ancillary reports used to generate the final report; unilateral changes were made based on the new requirements by the department generating the final report but were not communicated to other departments, causing further inconsistencies in subsequent ancillary reports; and errors in the final report were not identified during quality assurance processes due to human error.

Recommendation: Blue Cross Complete of Michigan was required to submit a CAP for elements 6.1, 6.2, 6.3, and 6.8, which were approved by MDHHS. As such, HSAG recommends that **Blue Cross Complete of Michigan** continue to implement action plans and monitoring processes for noncompliant elements under the OIG/Program Integrity standard to ensure that all data reported for program integrity purposes are accurate (i.e., *Tips and Grievances*, *Date Mining*, *Audits*, and *Encounter Adjustments* data).

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 262 cases by comparing provider data that **Blue Cross Complete of Michigan** submitted to HSAG against **Blue Cross Complete of Michigan**'s online provider directory. The sample included 148 PCPs, 106 pediatric providers, and eight OB/GYN providers (Table 3-22). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 96.2 percent (n=252) of the reviews. The sampled providers were not found in the online provider directory in 3.8 percent (n=10) of the reviewed cases.

Table 3-22—Summary of Providers Present in the Directory by Provider Category

		Providers Found in Directory		Providers Not Found in Directory	
Provider Category	Number of Sampled Providers	Count	%	Count	%
PCPs	148	144	97.3%	4	2.7%
Pediatric Providers	106	100	94.3%	6	5.7%
OB/GYN Providers	8	8	100%	0	0.0%
BCC Total	**262**	**252**	**96.2%**	**10**	**3.8%**

Table 3-23 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Blue Cross Complete of Michigan**'s provider data submission to HSAG and **Blue Cross Complete of Michigan**'s online provider directory.

Table 3-23—Provider Demographic Indicators Matching Online Provider Directory

	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%	Count	%
Provider's Name	144	100%	100	100%	8	100%	252	100%
Provider Street Address	125	86.8%	82	82.0%	8	100%	215	85.3%
Provider Suite Number	140	97.2%	90	90.0%	8	100%	238	94.4%
Provider City	131	91.0%	89	89.0%	8	100%	228	90.5%
Provider State	143	99.3%	100	100%	8	100%	251	99.6%
Provider ZIP Code	130	90.3%	86	86.0%	8	100%	224	88.9%
Provider Telephone Number	121	84.0%	82	82.0%	8	100%	211	83.7%

	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%	Count	%
Provider Type/Specialty	137	95.1%	99	99.0%	8	100%	244	96.8%
Provider Accepting New Patients	143	99.3%	100	100%	8	100%	251	99.6%
Provider Gender	144	100%	99	99.0%	8	100%	251	99.6%
Provider Primary Language*	144	100%	99	99.0%	8	100%	251	99.6%
Non-English Language Speaking Provider (including American Sign Language)*	142	98.6%	79	79.0%	1	12.5%	222	88.1%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 202 sampled provider locations (i.e., "cases") for **Blue Cross Complete of Michigan**, with an overall response rate of 55.0 percent (n=111). Table 3-24 summarizes the secret shopper survey results for **Blue Cross Complete of Michigan**.

Table 3-24—Summary of BCC Secret Shopper Survey Results

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
PCPs	114	52	45.6%	23	44.2%	19	36.5%	16	30.8%	11	21.2%
Pediatric Providers	80	52	65.0%	32	61.5%	32	61.5%	31	59.6%	30	57.7%
OB/GYN Providers	8	7	87.5%	4	57.1%	4	57.1%	4	57.1%	4	57.1%
BCC Total	**202**	**111**	**55.0%**	**59**	**53.2%**	**55**	**49.5%**	**51**	**45.9%**	**45**	**40.5%**

Table 3-25 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Blue Cross Complete of Michigan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-25—Appointment Availability Results

			Cases Offered an Appointment			Appointment Wait Time (Days)				
Provider Category	Total Survey Cases	Cases Accepting New Patients	Count	Rate Among All Surveyed Cases[1] (%)	Rate Among Cases Accepting New Patients[2] (%)	Min	Max	Average	Median	Percentage of Cases Within Standard[3]
PCPs	114	9	9	7.9%	100%	2	94	27	11	77.8%
Pediatric Providers	80	26	14	17.5%	53.8%	2	50	17	12	78.6%
OB/GYN Providers	8	3	1	12.5%	33.3%	32	32	32	32	0.0%
BCC Total	**202**	**38**	**24**	**11.9%**	**63.2%**	**2**	**94**	**21**	**12**	**75.0%**

[1] The denominator includes all surveyed cases included in the sample.
[2] The denominator includes cases responding to the survey that accept the insurance and new patients.
[3] The denominator includes cases offered an appointment. The MDHHS appointment timeliness standards are 30 business days for routine care appointments and seven business days for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Reviewers located over 96 percent of the sampled providers in **Blue Cross Complete of Michigan**'s online provider directory. Of the providers that reviewers located in the online directory, eight of 12 indicators had a match rate above 90 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 55.0 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **Blue Cross Complete of Michigan**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of the locations reached, only 53.2 percent confirmed affiliation with the sampled provider. Additionally, 49.5 percent confirmed accuracy of the sampled address, 45.9 percent confirmed the services were offered, and 40.5 percent confirmed the requested insurance was accepted. [**Quality** and **Access**]

Why the weakness exists: **Blue Cross Complete of Michigan**'s provider data included invalid provider, specialty, and insurance information.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

Weakness #3: Of the cases responding to the survey and accepting the insurance and new patients, only 63.2 percent of locations offered an appointment date. However, pediatric providers had an appointment availability rate of 53.8 percent, while OB/GYN provider locations had an appointment availability rate of 33.3 percent. [**Access**]

Why the weakness exists: For new **Blue Cross Complete of Michigan** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Blue Cross Complete of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **Blue Cross Complete of Michigan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Blue Cross Complete of Michigan**'s original questionnaire responses, and **Blue Cross Complete of Michigan** responded to these specific questions. To support its questionnaire responses, **Blue Cross Complete of Michigan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Blue Cross Complete of Michigan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-26 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-26—EDV Results for BCC

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• For medical claims, **Blue Cross Complete of Michigan** utilized Facets and Encounter Data Manager as its primary software for claim adjudication and encounter preparation. For dental claims, it used Sterling Integrator. • **Blue Cross Complete of Michigan** had processes in place to detect and identify duplicate claims. It submitted all encounters, including paid, denied, voided interest paid, recovered, and zero-paid claim lines. In cases requiring adjustments, the claim frequency code "7" was employed to denote an adjusted encounter. • **Blue Cross Complete of Michigan** and its subcontractors were responsible for collecting and maintaining provider information. Additionally, **Blue Cross Complete of Michigan** managed enrollment data received from MDHHS through 834 files, providing daily Medicaid enrollment updates to the MHPs for integration into their claim processing systems. **Blue Cross Complete of Michigan** ensured that subcontractors also

Analysis	Key Findings
	received and incorporated these enrollment details into their respective claim systems.
Payment Structures	• **Blue Cross Complete of Michigan** utilized the per diem and DRG methods for claim payment in inpatient encounters. For outpatient encounters, it employed percent billed and per diem methods. Pharmacy encounters were processed using ingredient cost, dispensing, and administrative fees methods. • In general, **Blue Cross Complete of Michigan** processed claims with TPL based on the collected insurance coverage information. When a claim suggests the existence of additional primary insurance for a member, the MHP's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details.
Encounter Data Quality Monitoring	• **Blue Cross Complete of Michigan** and/or its subcontractors performed several data quality checks on the encounter data collected. These checks included, but were not limited to, analyzing claim volume by submission month (for dental, laboratory, and pharmacy), assessing field-level completeness and validity (for all subcontractor encounters), evaluating timeliness (e.g., for all subcontractor encounters), and ensuring alignment between payment fields in claims and financial reports (for all subcontractor encounters except for NEMT). • For encounters collected by **Blue Cross Complete of Michigan**, it conducted file tracking checks and Electronic Data Interchange (EDI) compliance edit checks, assessed field-level completeness and accuracy, and verified the alignment of payment fields in claims with the financial reports.
Administrative Profile	
Encounter Data Completeness	• **Blue Cross Complete of Michigan** displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • **Blue Cross Complete of Michigan** had a low volume of duplicate encounters, with 0.3 percent of professional encounters, 0.1 percent of institutional encounters, 0.4 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative.
Encounter Data Timeliness	• **Blue Cross Complete of Michigan** demonstrated timely submission of professional, institutional, and dental encounters. Within 60 days, **Blue Cross Complete of Michigan** submitted 99.6 percent of professional encounters to MDHHS after the

Analysis	Key Findings
	payment date, and within 90 days, it submitted 99.5 percent of institutional encounters to MDHHS after the payment date. • Within 60 days, **Blue Cross Complete of Michigan** submitted 98.0 percent of dental encounters to MDHHS after the payment date, and within 150 days, it submitted 99.0 percent of dental encounters to MDHHS. • **Blue Cross Complete of Michigan** did not demonstrate timely submission of pharmacy encounters, with 62.9 percent of pharmacy encounters submitted to MDHHS within 60 days of the payment date. Within 360 days, **Blue Cross Complete of Michigan** remained consistent with 62.9 percent of pharmacy encounters submitted to MDHHS after the payment date. However, **Blue Cross Complete of Michigan**'s submitted data had the submit date prior to the payment date for 37.1 percent of pharmacy encounters.
Field-Level Completeness and Accuracy	• In **Blue Cross Complete of Michigan**'s submitted pharmacy encounters, the submit date was valid 62.9 percent of the time. • All other data elements in **Blue Cross Complete of Michigan**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Blue Cross Complete of Michigan**'s submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the enrollment data. • Of all identified member IDs in **Blue Cross Complete of Michigan**'s submitted pharmacy data, 99.9 percent were identified in the enrollment data. • Of all identified provider NPIs in **Blue Cross Complete of Michigan**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. • Of all identified provider NPIs in **Blue Cross Complete of Michigan**'s submitted pharmacy encounter data, 94.3 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Blue Cross Complete of Michigan**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Blue Cross Complete of Michigan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The MHP also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Blue Cross Complete of Michigan has a robust system for monitoring encounter data submissions designed to oversee the accuracy, completeness, and timeliness of encounter data, both from subcontractors and those collected directly by **Blue Cross Complete of Michigan**. [**Quality**]

Strength #3: Blue Cross Complete of Michigan submitted professional, institutional, and dental encounters in a timely manner from the payment date, with about 98 percent of all encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #4: Across all categories of service, key data elements for **Blue Cross Complete of Michigan** were populated at high rates and generally greater than 95 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 94 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: Blue Cross Complete of Michigan should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #2: Approximately 37 percent of **Blue Cross Complete of Michigan** pharmacy encounters had a submit date prior to the payment date. [**Quality**]

Why the weakness exists: Inaccurate date fields can lead to inaccurate timeliness metrics.

Recommendation: Blue Cross Complete of Michigan should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date is after the payment date field.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-27 presents **Blue Cross Complete of Michigan**'s 2022 and 2023 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-27—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for BCC

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Global Ratings				
Rating of Health Plan	69.14%	63.23%	70.98%	72.76%
Rating of All Health Care	59.20%	58.74%	74.80%	68.79%
Rating of Personal Doctor	65.57%	62.14% ↓	72.92%	72.97%
Rating of Specialist Seen Most Often	74.07%	63.36%	70.83%+	71.67%+
Composite Measures				
Getting Needed Care	83.50%	84.50%	82.82%+	83.22%
Getting Care Quickly	80.31%	82.90%	88.30%+	89.54%
How Well Doctors Communicate	92.11%	92.10%	95.33%	96.83% ↑
Customer Service	92.68%+	91.65%	84.96%+	88.04%+
Individual Item Measure				
Coordination of Care	90.80%+	85.22%	75.47%+	82.76%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	74.48%	75.48%	—	—
Discussing Cessation Medications	51.56%	54.49%	—	—
Discussing Cessation Strategies	43.98%	47.40%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Blue Cross Complete of Michigan's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, *How Well Doctors Communicate*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Blue Cross Complete of Michigan's 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for one measure, *Rating of Personal Doctor*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that **Blue Cross Complete of Michigan**'s members are reporting a more negative experience with their personal doctor, since the score for this measure was statistically significantly below the 2022 NCQA adult Medicaid national average. However, HSAG is unable to identify the MHP-specific barriers or other factors as reported through the Member Advisory Group that may be impacting key drivers for this measure.

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the MHP members. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers. Also, physicians could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their conditions and the actions they will take to monitor and manage their conditions.

Performance Results—CSHCS

Table 3-28 presents **Blue Cross Complete of Michigan**'s 2022 and 2023 CSHCS CAHPS top-box scores. The following measure could not be displayed in the table because this measure had fewer than 11 responses and was suppressed: *Transportation*. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-28—Summary of CSHCS CAHPS Survey Top-Box Scores for BCC

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	69.44%	65.49%
Rating of Health Care	69.57%	68.30% NA
Rating of Specialist Seen Most Often	73.65%	70.48%
Rating of CMDS Clinic	63.64%+	55.56%+ NA
Composite Measures		
Customer Service	82.09%+	82.35%+ NA
How Well Doctors Communicate	94.33%	92.52% NA
Access to Specialized Services	67.72%+	67.06%+ NA
Individual Item Measures		
Access to Prescription Medicines	87.50%	85.80%
CMDS Clinics	76.47%+	67.86%+ NA
Local Health Department Services	76.19%+	79.69%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	95.34%	97.55% NA
Not Felt Treated Unfairly: Health Insurance Type	94.33%	95.73% NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Blue Cross Complete of Michigan's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Blue Cross Complete of Michigan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-29 presents **Blue Cross Complete of Michigan**'s 2022 and 2023 HMP CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-29—Summary of HMP CAHPS Top-Box Scores for BCC

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	61.58%	66.37%
Rating of All Health Care	58.49%	58.04%
Rating of Personal Doctor	68.38%	69.66%
Rating of Specialist Seen Most Often	67.61%$^{+}$	71.43%$^{+}$
Composite Measures		
Getting Needed Care	83.59%$^{+}$	86.70%$^{+}$
Getting Care Quickly	82.22%$^{+}$	85.60%$^{+}$

	2022 Top-Box Score	2023 Top-Box Score
How Well Doctors Communicate	96.18%+	96.48% ↑
Customer Service	86.27%+	88.67%+
Individual Item Measure		
Coordination of Care	88.89%+	93.33%+ ↑
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	82.14%	78.51%
Discussing Cessation Medications	63.39%	63.64% ↑
Discussing Cessation Strategies	55.36%	61.16% ↑

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Blue Cross Complete of Michigan's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for four measures: *How Well Doctors Communicate*, *Coordination of Care*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Blue Cross Complete of Michigan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Blue Cross Complete of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide, which is inclusive of **Blue Cross Complete of Michigan**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **Blue Cross Complete of Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Blue Cross Complete of Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Blue Cross Complete of Michigan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-30 displays each applicable performance area and the overall performance impact related to the quality, timeliness, and accessibility of healthcare services provided to **Blue Cross Complete of Michigan**'s Medicaid members.

Table 3-30—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access**—**Blue Cross Complete of Michigan** continued its MDHHS-mandated PIP focused on disparities in timeliness of prenatal care between Black women residing in Region 10 and White women residing in Region 10. **Blue Cross Complete of Michigan** demonstrated both clinically and programmatically significant improvement over the baseline performance for the disparate population (Black women) through intervention strategies specifically targeted toward this population; all Black women were stratified as high risk and were prioritized to receive outreach by a nurse case manager, and a peer-led pregnancy group was launched where Black women could receive pregnancy related education. Additionally, the HEDIS audit results documented within the 2023 HEDIS Aggregate Report for Michigan Medicaid located in Appendix B confirmed **Blue Cross Complete of Michigan**'s rate for the *Timeliness of Prenatal Care* measure ranked between the 50th and 74th Medicaid Quality Compass percentile, indicating many women were receiving prenatal care in the first trimester. Prenatal care during the first trimester can lower the risk of pregnancy complications. Further, as demonstrated through the compliance review activity, **Blue Cross Complete of Michigan** met MDHHS' expectations for addressing health disparities through population health management as demonstrated by a 100 percent compliance score for the Quality standard; and specifically, a *Met* score for element *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*. **Blue Cross Complete of Michigan** demonstrated it had adequate policies and procedures for providing population health management

Performance Area	Overall Performance Impact
	services. **Blue Cross Complete of Michigan** should continue to conduct data analysis through its quality program to identify and subsequently implement interventions to reduce disparities in healthcare. However, while **Blue Cross Complete of Michigan**'s PIP and PMV results demonstrated mostly positive results, the MHP's PIP did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period, and the comparison group (White women) demonstrated a non-statistically significant decrease in performance as compared to the baseline rate. Further, **Blue Cross Complete of Michigan**'s rate for the *Timeliness of Prenatal Care* as reported in Appendix B also demonstrated a slight decline from the prior year. **Blue Cross Complete of Michigan** should closely monitor for continued negative trends and conduct barrier analyses to determine whether there may be new barriers preventing women from receiving timely prenatal care appointments. Further, the results of the NAV activity may indicate that some of **Blue Cross Complete of Michigan**'s members may be experiencing challenges contacting or scheduling appointments with OB/GYN providers due to invalid information within the provider directory, including provider telephone or address, provider type/specialty, and/or provider accepting insurance information. **Blue Cross Complete of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members to further ensure members are able to obtain timely prenatal care.
Preventive Care	**Quality**, **Timeliness**, and **Access**—**Blue Cross Complete of Michigan** demonstrated strengths of its program through the PMV activity pertaining to preventive care, as all rates for the *Chlamydia Screening in Women*, *Cervical Cancer Screening*, and *Breast Cancer Screening* measures ranked between the 50th and 74th or the 75th and 89th Medicaid Quality Compass percentiles. All rates also demonstrated an increase from the prior year. with the three rates for *Chlamydia Screening in Women* demonstrating a statistically significant improvement. Additionally, **Blue Cross Complete of Michigan**'s rate for *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* ranked at or above the 90th percentile and demonstrated a statistically significant improvement from the prior year. Preventive care and screenings can monitor growth and development, reduce the chance of obtaining a vaccine preventable condition, and lead to early detection of cancer. Further, as demonstrated through the compliance review activity, **Blue Cross Complete of Michigan** met MDHHS' expectations for monitoring appointment wait times for preventive services. Specifically, **Blue Cross Complete of Michigan** received a *Met* score for element *2.10 Provider Wait Times* under the Providers standard, which included, but was not limited to, monitoring of the following metrics: *Routine Care is available within 30*

Performance Area	Overall Performance Impact
	Business Days of request, *Routine Dental Care is within 21 Business Days of request*, and *Preventive Dental Services is within six weeks of request*. However, while three of the four rates under the *Child and Adolescent Well-Care Visit* measure performed well overall (i.e., between the 50th and 74th Medicaid Quality Compass percentile), the rate for children ages 12 to 17 years only ranked between the 25th and 49th percentile, and this age group as well as the rate for ages 18 to 21 years demonstrated a statistically significant decline from the prior year. **Blue Cross Complete of Michigan** should continue to monitor the performance of this measure and implement initiatives to ensure members of all ages receive an annual well-care visit. Additionally, the results of the NAV activity indicate that some of **Blue Cross Complete of Michigan**'s members may be experiencing challenges in making appointments with PCPs or pediatric providers due to inaccurate information within **Blue Cross Complete of Michigan**'s provider directory, and provider offices informing members that they do not accept **Blue Cross Complete of Michigan** Medicaid insurance. Further, of providers responding to the survey and accepting the insurance and new patients, only 53.8 percent of pediatric providers offered an appointment, and only 77.8 percent and 78.6 percent of PCPs and pediatric providers, respectively, offered a timely appointment that met MDHHS' appointment timeliness standard of 30 business days. **Blue Cross Complete of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates were 72.97 percent and 69.66 percent, respectively. For the adult Medicaid population, the rate for *Rating of Personal Doctor* was 62.14 percent and was statistically significantly lower than the national average. **Blue Cross Complete of Michigan** should also consider these results when determining potential barriers for members accessing preventive care.
Care for Chronic Conditions	**Quality**, **Timeliness**, and **Access**—Overall, **Blue Cross Complete of Michigan** demonstrated mostly positive results through the PMV and compliance activities as it pertains to chronic conditions. For the *Hemoglobin A1c Control for Patients With Diabetes, Eye Exam for Patients With Diabetes*, *Blood Pressure Control for Patients With Diabetes*, and *Kidney Health Evaluation for Patients With Diabetes*, five rates ranked between the 50th and 74th Medicaid Quality Compass percentile, two rates ranked between the 75th and 89th percentile, and one rate ranked at or above the 90th. Seven of these rates also increased in performance from the prior year, with five of those rates demonstrating a statistically significant improvement. These results indicate

Performance Area	Overall Performance Impact
	that more of **Blue Cross Complete of Michigan**'s members were receiving care to manage their chronic conditions. Appropriate management of chronic conditions can reduce symptoms and the chance of serious complications and improve quality of life. Further, as demonstrated by a *Met* score for element *3.10 CSHCS PCP Requirements* under the Members standard within the compliance review activity, **Blue Cross Complete of Michigan** met MDHHS' expectations for assignment of PCPs for children and youth with complex chronic conditions. However, the results of the NAV activity indicated that some of **Blue Cross Complete of Michigan**'s members may be experiencing challenges making appointments with PCPs due to inaccurate provider directory information, and PCP offices indicating they do not accept **Blue Cross Complete of Michigan** Medicaid insurance or new patients. Additionally, while 100 percent of PCPs accepting new patients offered an appointment, only 77.8 percent of those offering a timely appointment met the MDHHS appointment timeliness standard of 30 business days. **Blue Cross Complete of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements. Further, the *Controlling High Blood Pressure* measure ranked between the 25th and 49th percentile, indicating that many of **Blue Cross Complete of Michigan**'s members diagnosed with hypertension did not have their blood pressure adequately controlled. According to the CDC, hypertension puts individuals at risk for heart disease and stroke, which are the leading causes of death in the nation. **Blue Cross Complete of Michigan** should continue efforts to identify interventions to mitigate barriers to care and ensure its members' blood pressures are appropriately managed. Lastly, while the CAHPS measure, *Rating of Personal Doctor*, for the child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates were 72.97 percent and 69.66 percent, respectively. For the adult Medicaid population, the rate for *Rating of Personal Doctor* was 62.14 percent and was statistically significantly lower than the national average. **Blue Cross Complete of Michigan** should also consider these results when determining potential barriers for members accessing care for chronic conditions.
Health Information Systems and Technology	**Quality**, **Timeliness**, and **Access— Blue Cross Complete of Michigan** demonstrated strengths of its health information systems and technology through the PMV, compliance, and EDV activities. The PMV findings confirmed that **Blue Cross Complete of Michigan** was fully compliant with how it collected, stored, analyzed, and reported HEDIS data. All rates were *Reportable*, indicating that **Blue Cross Complete of Michigan** followed the NCQA technical specifications for the calculation of HEDIS performance

Performance Area	Overall Performance Impact
	measures. Additionally, although **Blue Cross Complete of Michigan** scored below the statewide average for the MIS/Financial standard of the compliance review, it received a score of 95 percent, indicating that it met MDHHS' expectations for most requirements pertaining to **Blue Cross Complete of Michigan**'s MIS. Further, through the EDV activity, **Blue Cross Complete of Michigan** demonstrated its capability to collect, process, and transmit encounter data to MDHHS; submit encounter data timely; and populate valid key data elements for all service categories. **Blue Cross Complete of Michigan** also had comprehensive processes for monitoring the accuracy, completeness, and timeliness of encounter data. However, as less pharmacy provider NPIs were identified in provider data than medical and dental provider NPIs, **Blue Cross Complete of Michigan** should also collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers. Additionally, as approximately 37 percent of **Blue Cross Complete of Michigan** pharmacy encounters had a submit date prior to the payment date, **Blue Cross Complete of Michigan** should implement quality checks to ensure the submission date is after the payment date. Lastly, as demonstrated through the compliance review, **Blue Cross Complete of Michigan** was not fully compliant with the *Accurate NCPDP 70 Rejections*, *Must have less than 0.1% noncompliant claims for products covered on the Common Formulary,* and *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS* (related to dental invoice types) metrics under compliance review elements *5.6 Pharmacy/MCO Common Formulary* and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. Therefore, **Blue Cross Complete of Michigan** should continue to implement action plans and monitoring processes to ensure all claims processing performance standards are consistently met.

HAP Empowered

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2023 evaluated the technical methods of **HAP Empowered**'s PIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG determined the overall methodological validity of the PIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-31 displays the overall validation rating, the baseline rate, Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-31—Overall Validation Rating for HAP

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Improving the Timeliness of Prenatal Care	*Met*	Measuring the percentage of Black/African-American pregnant women who have a prenatal visit within 42 days of enrollment or within the first trimester	72.4%	75.1% ⇔		NA

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
NA = The MHP did not identify a disparity within its population; therefore, an assessment of an existing disparity during R1 is not applicable.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MHP conducted accurate data analysis and interpretation of PIP results; overall confidence that the PIP produced significant evidence of improvement).

Due to its small population size and lack of an identified disparity, **HAP Empowered** determined through data analysis that the focus for the PIP should be improving timeliness of prenatal care for Black/African-American pregnant women as this population was the lowest-performing subgroup. The goal for **HAP Empowered**'s PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods or achieve clinically or programmatically significant improvement as the result of an intervention. Table 3-32 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-32—Remeasurement 1 Barriers and Interventions for HAP

Barriers	Interventions
Lack of member outreach/engagement.	Outreached to engage members in the internal case management program for maternity utilizing monthly pregnancy reports.
	Implemented a maternity-focused care management program powered by ProgenyHealth. Progeny also outreached to engage members and refer to MIHPs.
Lack of response to member incentive program.	Continued outreach strategies to engage members and educate them on the incentive program. Implemented text messaging campaign to educate and engage members.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered did not achieve significant improvement over the baseline performance for the first remeasurement period. [**Quality**, **Access,** and **Timeliness**]

Why the weakness exists: While it is unclear why the performance indicator or interventions did not achieve significant improvement over the baseline performance, **HAP Empowered** made progress in improving the performance for the indicator.

Recommendation: HSAG recommends that **HAP Empowered** revisit its causal/barrier analysis to determine if any new barriers exist for the Black/African-American population that require the development of targeted strategies to further improve performance.

Performance Measure Validation

Performance Results

HAP Empowered was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2022 Compliance Audit Report findings, **HAP Empowered** was fully compliant with all seven IS standards.

According to the auditor's review, **HAP Empowered** followed the NCQA HEDIS MY 2022 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-33 displays the MDHHS-selected performance measures, HEDIS MY 2021 and MY 2022 rates, MY 2021 and MY 2022 comparisons, and MY 2022 performance levels based on comparisons to national percentiles[3-18] for **HAP Empowered**. Additional performance measures and performance measure results for **HAP Empowered** can be referenced in Appendix B.

Table 3-33—HEDIS MY 2022 Performance Measure Results for HAP

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	36.06%	52.44%	+16.38+	★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	46.05%	47.35%	+1.30	★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	45.80%	47.26%	+1.46	★
Ages 12 to 17 Years	34.35%	36.91%	+2.56	★
Ages 18 to 21 Years	19.18%	22.12%	+2.94	★★
Total	36.69%	38.98%	+2.29+	★
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	55.87%	64.90%	+9.03+	★★★★
Ages 21 to 24 Years	60.48%	66.17%	+5.69+	★★★
Total	58.96%	65.78%	+6.82+	★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	43.80%	56.45%	+12.65+	★★

[3-18] HEDIS MY 2022 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2021 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Breast Cancer Screening				
Breast Cancer Screening	56.75%	54.95%	-1.80	★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)**	50.12%	35.77%	-14.35+	★★★
HbA1c Control (<8.0%)	44.28%	56.20%	+11.92+	★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	49.88%	58.88%	+9.00+	★★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	53.28%	61.07%	+7.79+	★★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	31.20%	37.86%	+6.66+	★★★
Ages 65 to 74 Years	33.55%	44.93%	+11.38+	★★★
Ages 75 to 85 Years	32.35%	43.10%	+10.75	★★★
Total	31.83%	39.52%	+7.69+	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	57.32%	62.53%	+5.21	★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered's performance ranked between the 75th and 89th percentile for the *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Total* measure indicators, which is a

significant improvement from the previous year, indicating women identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-19] [**Quality**]

Strength #2: HAP Empowered's performance ranked between the 75th and 89th percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicator, which is a marked improvement from the prior year, indicating that members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-20] [**Quality** and **Access**]

Strength #3: HAP Empowered's performance ranked between the 75th and 89th percentile for the *Eye Exam for Patients With Diabetes* measure indicator, indicating members with diabetes had an eye exam to screen or monitor for diabetic retinal disease most of the time. Left unmanaged, diabetes can lead to serious complications, including blindness.[3-21] [**Quality** and **Access**]

Strength #4: HAP Empowered demonstrated overall strength in its HEDIS data reporting, as **HAP Empowered** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentile. Additionally, performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 15 months old during the measurement year were not always having at least six well-child visits with a PCP during their first 15 months of life. Additionally, children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-22] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While the rates for both *Well-Child Visits in the First 30 Months of Life* measure indicators demonstrated improvement from MY 2021 to MY 2022, the rates ranked between the 25th and 49th percentile and below the 25th percentile, respectively. Some barriers noted by **HAP Empowered** included incorrect member contact information, resulting in unsuccessful member outreach, and SDOH, such as housing and food insecurities.

3-19 National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Mar 7, 2024.

3-20 National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.

3-21 Ibid.

3-22 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

Recommendation: While **HAP Empowered** noted several interventions currently in place to target improvement, such as distributing gap-in-care letters to members, revamping its member rewards program, hiring outreach specialists to remind members of preventive care, providing member education, and addressing SDOH, performance remains low for both *Well-Child Visits in the First 30 Months of Life* measure indicators. Therefore, HSAG recommends that **HAP Empowered** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #2: HAP Empowered's performance for the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years*, *Ages 12 to 17 Years*, and *Total* measure indicators ranked below the 25th percentile, and performance for the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* ranked between the 25th and 49th percentile, indicating children between the ages 3 and 21 years were not always getting one or more well-care visits during the measurement year. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-23] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: While the rates for all *Child and Adolescent Well-Care Visits* measure indicators demonstrated improvement from MY 2021 to MY 2022, performance for the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years*, *Ages 12 to 17 Years*, and *Total* measure indicators ranked below the 25th percentile, and performance for the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* measure indicator ranked between the 25th and 49th percentile. Some barriers noted by **HAP Empowered** included incorrect member contact information, resulting in unsuccessful member outreach, and SDOH, such as housing and food insecurities. SDOH, such as housing, education, and employment needs, can adversely impact a parent's ability to ensure timely well-care visits.[3-24]

Recommendation: While **HAP Empowered** noted several interventions currently in place to target improvement, such as distributing gap-in-care letters to members, revamping its member rewards program, hiring outreach specialists to remind members of preventive care, providing member education, and addressing SDOH, performance remains low for the *Child and Adolescent Well-Care Visits* measures indicators. Therefore, HSAG recommends that **HAP Empowered** continue its efforts to improve performance for the *Child and Adolescent Well-Care Visits* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **HAP Empowered** could consider working with providers to integrate appointment barrier screening into appointment reminder calls or notifications.

Weakness #3: HAP Empowered's performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for cervical cancer. Cervical cancer is one of the most common causes of cancer death for American

[3-23] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

[3-24] National Library of Medicine. Caregiver and Clinician Perspectives on Missed Well-Child Visits. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7227475/. Accessed on: Mar 7, 2024.

women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-25] [**Quality** and **Access**]

Why the weakness exists: While the rate for the *Cervical Cancer Screening* measure demonstrated improvement from MY 2021 to MY 2022, performance for the *Cervical Cancer Screening* measure ranked between the 25th and 49th percentile. Some barriers noted by **HAP Empowered** included screenings not being completed during doctor visits, SDOH, and incorrect member contact information.

Recommendation: While **HAP Empowered** noted several interventions currently in place to target improvement, such as facilitating women's events to offer needed screenings, strengthening partnerships with providers, and offering a $50 reward for members who completed an annual doctor visit where screenings could be completed, performance remains low for the *Cervical Cancer Screening* measure. Therefore, HSAG recommends that **HAP Empowered** continue its efforts to improve performance for the *Cervical Cancer Screening* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **HAP Empowered** could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.

[3-25] National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Mar 7, 2024.

Compliance Review

Performance Results

Table 3-34 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-34 also presents **HAP Empowered**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **HAP Empowered** was subject to a corrective action review process outlined in Appendix A.

Table 3-34—Compliance Review Results for HAP

Standard		Number of Scores			Compliance Scores	
		Met	*Satisfied*[1]	*Not Met*	HAP[2]	Statewide[3]
1	Administrative	5	0	0	100%	100%
2	Providers	22	0	1	96%	94.7%
3	Members	29	0	1	97%	97.7%
4	Quality	22	0	0	100%	99.5%
5	MIS/Financial	38	2	0	95%	96.1%
6	OIG/Program Integrity	33	0	2	94%	90.2%
Overall		**148**	**2**	**4**	**96%**	**95.5%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

[2] MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

[3] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **HAP Empowered** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: HAP Empowered achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs; QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: While **HAP Empowered** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *3.1 Member Material – ID Card and Member Handbook*. [**Timeliness** and **Access**]

Why the weakness exists: There was no indication the member packets with ID cards and handbooks were mailed within 10 business days of notification of enrollment. **HAP Empowered** reported that its print vendor had a ransomware breach that halted the printing of both the welcome kit and ID cards and the MHP had to rebuild a process to trigger the mailing of the welcome kit and handbook with a new print vendor.

Recommendation: HAP Empowered was required to submit a CAP to address element 3.1, which was approved by MDHHS. As such, HSAG recommends that **HAP Empowered** continue to implement action plans and monitoring processes to ensure member ID cards and member handbooks are mailed timely.

Weakness #2: While **HAP Empowered** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Satisfied* score for elements *5.14 Monthly Pharmacy Encounter Timeliness* and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. [**Quality** and **Timeliness**]

Why the weakness exists: HAP Empowered did not meet the timeliness standard for pharmacy invoice types for one payment month. The MHP reported that its quality initiative, which increased the volume of prescription fills for extended days supplies, sporadically impacted its prescription/encounter volume. Additionally, **HAP Empowered** did not meet the 95 percent encounter acceptance rate for dental invoice types for one reporting month. The MHP reported that the issue involved adjustments to encounters that were submitted as original encounters.

Recommendation: MDHHS did not require a CAP for elements 5.14 and 5.15 as **HAP Empowered** met the standards in subsequent reporting months. As such, HSAG recommends that **HAP Empowered** continue to implement action plans and monitoring processes to ensure that all encounter processing performance standards are consistently met (i.e., *Submitted and accepted*

records must meet or exceed the minimum volume calculated by MDHHS and *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS*).

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 334 cases by comparing provider data that **HAP Empowered** submitted to HSAG against **HAP Empowered**'s online provider directory. The sample included 167 PCPs and 167 pediatric providers (Table 3-35). For SFY 2023, the eligible population criteria were updated to limit to those providers with the PCP indicator, which reduced the number of eligible OB/GYN providers. Due to this change, no OB/GYN providers were sampled for HAP. Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 97.9 percent (n=327) of the reviews. The sampled providers were not found in the online provider directory in 2.1 percent (n=7) of the reviewed cases.

Table 3-35—Summary of Providers Present in the Directory by Provider Category

		Providers Found in Directory		Providers Not Found in Directory	
Provider Category	Number of Sampled Providers	Count	%	Count	%
PCPs	167	164	98.2%	3	1.8%
Pediatric Providers	167	163	97.6%	4	2.4%
HAP Total	**334**	**327**	**97.9%**	**7**	**2.1%**

Table 3-36 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **HAP Empowered**'s provider data submission to HSAG and **HAP Empowered**'s online provider directory.

Table 3-36—Provider Demographic Indicators Matching Online Provider Directory

	PCPs		Pediatric Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%
Provider's Name	164	100%	161	98.8%	325	99.4%
Provider Street Address	160	97.6%	153	93.9%	313	95.7%
Provider Suite Number	161	98.2%	157	96.3%	318	97.2%
Provider City	163	99.4%	155	95.1%	318	97.2%
Provider State	164	100%	163	100%	327	100%

	PCPs		Pediatric Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%
Provider ZIP Code	163	99.4%	155	95.1%	318	97.2%
Provider Telephone Number	160	97.6%	152	93.3%	312	95.4%
Provider Type/Specialty	164	100%	163	100%	327	100%
Provider Accepting New Patients	164	100%	162	99.4%	326	99.7%
Provider Gender	164	100%	162	99.4%	326	99.7%
Provider Primary Language*	148	90.2%	11	6.7%	159	48.6%
Non-English Language Speaking Provider (including American Sign Language)*	162	98.8%	156	95.7%	318	97.2%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 309 sampled provider locations (i.e., "cases") for **HAP Empowered**, with an overall response rate of 69.9 percent (n=216). Table 3-37 summarizes the secret shopper survey results for **HAP Empowered**.

Table 3-37—Summary of HAP Secret Shopper Survey Results

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
PCPs	160	98	61.3%	65	66.3%	56	57.1%	42	42.9%	23	23.5%
Pediatric Providers	149	118	79.2%	99	83.9%	97	82.2%	92	78.0%	75	63.6%
HAP Total	**309**	**216**	**69.9%**	**164**	**75.9%**	**153**	**70.8%**	**134**	**62.0%**	**98**	**45.4%**

Table 3-38 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **HAP Empowered**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-38—Appointment Availability Results

			Cases Offered an Appointment			Appointment Wait Time (Days)				
Provider Category	Total Survey Cases	Cases Accepting New Patients	Count	Rate Among All Surveyed Cases[1] (%)	Rate Among Cases Accepting New Patients[2] (%)	Min	Max	Average	Median	Percentage of Cases Within Standard[3]
PCPs	160	23	6	3.8%	26.1%	2	14	6	4	100%
Pediatric Providers	149	69	50	33.6%	72.5%	0	52	8	6	94.0%
HAP Total	**309**	**92**	**56**	**18.1%**	**60.9%**	**0**	**52**	**8**	**6**	**94.6%**

[1] The denominator includes all surveyed cases included in the sample.
[2] The denominator includes cases responding to the survey that accept the insurance and new patients.
[3] The denominator includes cases offered an appointment. The MDHHS appointment timeliness standard is 30 business days for routine care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Reviewers located over 97 percent of the sampled providers in **HAP Empowered**'s online provider directory. Of the providers that reviewers located in the online directory, 11 of 12 indicators had a match rate above 95 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 69.9 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **HAP Empowered**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **HAP Empowered** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of the locations reached, only 75.9 percent confirmed affiliation with the sampled provider. Additionally, 70.8 percent confirmed accuracy of the sampled address, 62.0 percent confirmed the services were offered, and 45.4 percent confirmed the requested insurance was accepted. [**Quality** and **Access**]

Why the weakness exists: **HAP Empowered**'s provider data included invalid provider, specialty, and insurance information.

Recommendation: HSAG recommends that **HAP Empowered** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

Weakness #3: Of the cases responding to the survey and accepting the insurance and new patients, only 60.9 percent of locations offered an appointment date. However, PCP locations had an appointment availability rate of 86.1 percent. [**Access**]

Why the weakness exists: For new **HAP Empowered** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **HAP Empowered** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **HAP Empowered** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **HAP Empowered** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **HAP Empowered**'s original questionnaire responses, and **HAP Empowered** responded to these specific questions. To support its questionnaire responses, **HAP Empowered** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **HAP Empowered** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-39 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-39—EDV Results for HAP

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **HAP Empowered** utilized Facets and Change Healthcare as its primary software for claim adjudication and encounter preparation. • **HAP Empowered** had processes in place to detect and identify duplicate claims. **HAP Empowered** clarified that it did not submit encounters for certain scenarios, including pharmacy claims that were reversed out, paid, and voided in the same cycle; administrative expense claims; non-U.S. billing providers; duplicates; member ineligibility; missing data; and invalid diagnoses. In cases requiring adjustments, the claim frequency code "7" is used to indicate an adjusted encounter. • **HAP Empowered** and its subcontractors were responsible for collecting and maintaining provider information. Express Scripts managed member enrollment data, utilizing it in the adjudication process. The data were obtained from the MHP through a data feed to Express Scripts, which helped determine the member's status (active or terminated) on the date of service. Additionally, Joint Venture Hospital Laboratories (JVHL), Nations Hearing, Aspire, Veyo, and Delta Dental received weekly enrollment files from **HAP Empowered**.

Analysis	Key Findings
	HAP Empowered actively managed enrollment data received from MDHHS via 834 files, facilitating daily Medicaid enrollment updates to the MHPs for integration into their claim processing systems. The assurance extended to subcontractors, ensuring that they also received and incorporated these enrollment details into their respective claim systems.
Payment Structures	• **HAP Empowered** employs various claim payment methods for different encounter types. In inpatient encounters, it utilized line-by-line, per diem, DRG, negotiated (flat) rate, Ambulatory Payment Classification (APC), and CMS pricing methods for claim payment. For outpatient encounters, the methods included percent billed, line-by-line, per diem, variable per diem, capitation, and negotiated (flat) rate. Pharmacy encounters were processed using the ingredient cost method. • In general, **HAP Empowered** processed claims with TPL based on the collected insurance coverage information. When a claim suggests the existence of additional primary insurance for a member, the MHP's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details.
Encounter Data Quality Monitoring	• **HAP Empowered** indicated that it edited or made modifications to some of the subcontractor data (i.e., dental, hearing, and laboratory). • **HAP Empowered** and/or its subcontractors performed several data quality checks on the encounter data collected by the subcontractors. These checks included, but were not limited to, analyzing claim volume by submission month (for hearing and palliative care, NEMT, and pharmacy), assessing field-level completeness and validity (for all subcontractor encounters except laboratory), evaluating timeliness (for pharmacy), and ensuring alignment between payment fields in claims and financial reports (for all subcontractor encounters except for laboratory). • For encounters collected by **HAP Empowered**, it conducted claim volume by submission month and EDI compliance edit checks, and verified the alignment of payment fields in claims with the financial reports.
Administrative Profile	
Encounter Data Completeness	• **HAP Empowered** displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year.

Analysis	Key Findings
	• **HAP Empowered** had a low volume of duplicate encounters, with less than 0.1 percent of professional encounters, 0.1 percent of institutional encounters, 0.4 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative.
Encounter Data Timeliness	• **HAP Empowered** demonstrated timely submission of professional, institutional, and dental encounters. Within 60 days, **HAP Empowered** submitted 99.5 percent of professional encounters to MDHHS after the payment date, and within 90 days, it submitted 99.2 percent of institutional encounters to MDHHS after the payment date. • Within 60 days, **HAP Empowered** submitted greater than 99.9 percent of dental encounters, and within 120 days, it submitted 100 percent of dental encounters to MDHHS after the payment date. • **HAP Empowered** did not demonstrate timely submission of pharmacy encounters, with 76.1 percent of pharmacy encounters submitted to MDHHS within 60 days of the payment date. Within 360 days, **HAP Empowered** remained consistent with 76.2 percent of pharmacy encounters submitted to MDHHS after the payment date. However, **HAP Empowered**'s submitted data had the submit date prior to the payment date for 23.8 percent of pharmacy encounters.
Field-Level Completeness and Accuracy	• In **HAP Empowered**'s submitted pharmacy encounters, the submit date was valid 76.2 percent of the time. • All other data elements in **HAP Empowered**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **HAP Empowered**'s submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the enrollment data. • Of all identified member IDs in **HAP Empowered**'s submitted pharmacy data, 99.7 percent were identified in the enrollment data. • Of all identified provider NPIs in **HAP Empowered**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. • Of all identified provider NPIs in **HAP Empowered**'s submitted pharmacy encounter data, 97.6 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **HAP Empowered**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The MHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: HAP Empowered submitted professional, institutional, and dental encounters in a timely manner from the payment date, with about 99 percent of all encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all categories of service, key data elements for **HAP Empowered** were populated at high rates and generally greater than 95 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered modified encounters from its subcontractors before submitting them to MDHHS. [**Quality**]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: HAP Empowered should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: HAP Empowered did not indicate any quality checks performed for claims/encounters from its laboratory subcontractor. [**Quality**]

Why the weakness exists: Ensuring data accuracy, completeness, and timeliness requires the implementation of claims/encounter quality checks.

Recommendation: HAP Empowered should develop a comprehensive suite of monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its subcontractor.

Weakness #3: Approximately 24 percent of **HAP Empowered** pharmacy encounters had a submit date prior to the payment date. [**Quality**]

Why the weakness exists: Inaccurate date fields can lead to inaccurate timeliness metrics.

Recommendation: HAP Empowered should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date is after the payment date field.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-40 presents **HAP Empowered**'s 2022 and 2023 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-40—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for HAP

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Global Ratings				
Rating of Health Plan	64.22%	63.89%	71.30%	69.14%
Rating of All Health Care	59.29%	57.14%	64.20%+	69.70%+
Rating of Personal Doctor	72.68%	71.03%	71.72%+	72.46%
Rating of Specialist Seen Most Often	67.78%+	63.10%+	76.67%+	84.85%+
Composite Measures				
Getting Needed Care	80.93%	80.54%	82.68%+	79.24%+
Getting Care Quickly	85.21%+	78.70%+	86.94%+	87.50%+
How Well Doctors Communicate	95.35%	93.32%	93.32%+	93.96%
Customer Service	91.64%	90.26%+	90.54%+	86.79%+
Individual Item Measure				
Coordination of Care	84.93%+	86.67%+	87.10%+	82.35%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	70.73%	65.69%	—	—
Discussing Cessation Medications	51.61%	46.08%	—	—
Discussing Cessation Strategies	44.35%	38.83%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA adult and child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: HAP Empowered's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult and child Medicaid national averages or 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **HAP Empowered** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—CSHCS

Table 3-41 presents **HAP Empowered**'s 2022 and 2023 CSHCS CAHPS top-box scores. The following measures could not be displayed in the table because these measures had fewer than 11 responses and were suppressed: *Rating of Specialist Seen Most Often*, *Rating of CMDS Clinic*, *Customer Service*, *Access to Specialized Services*, *Transportation*, *Access to Prescription Medicines*, *CMDS Clinic*, and *Local Health Department Services*. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-41—Summary of CSHCS CAHPS Survey Top-Box Scores for HAP

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	61.54%$^{+}$	76.92%$^{+}$
Rating of Health Care	50.00%$^{+}$	76.92%$^{+}$ NA
Composite Measures		
How Well Doctors Communicate	95.83%$^{+}$	100%$^{+}$ NA

	2022 Top-Box Score	2023 Top-Box Score
Individual Item Measures		
Not Felt Treated Unfairly: Race and Ethnicity	100%+	100%+ NA
Not Felt Treated Unfairly: Health Insurance Type	100%+	100%+ NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: HAP Empowered's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **HAP Empowered** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-42 presents **HAP Empowered**'s 2022 and 2023 HMP CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-42—Summary of HMP CAHPS Top-Box Scores for HAP

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	56.43%	66.15%
Rating of All Health Care	54.55%+	60.56%+
Rating of Personal Doctor	68.09%+	70.83%+
Rating of Specialist Seen Most Often	63.04%+	75.93%+
Composite Measures		
Getting Needed Care	82.77%+	79.96%+
Getting Care Quickly	78.16%+	86.67%+
How Well Doctors Communicate	94.03%+	98.96%+ ↑
Customer Service	85.53%+	81.40%+
Individual Item Measure		
Coordination of Care	90.48%+	83.33%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	63.64%+	64.94%+
Discussing Cessation Medications	45.45%+	48.05%+
Discussing Cessation Strategies	36.84%+	39.47%+

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.

Strengths, Weaknesses, and Recommendations—HMP

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an

identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HAP Empowered's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *How Well Doctors Communicate*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: HAP Empowered's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **HAP Empowered** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide, which is inclusive of **HAP Empowered**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **HAP Empowered**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **HAP Empowered** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **HAP Empowered**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-43 displays each applicable performance area and the overall performance impact related to the quality, timeliness, and accessibility of healthcare services provided to **HAP Empowered**'s Medicaid members.

Table 3-43—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access**—**HAP Empowered** continued its MDHHS-mandated PIP focused on disparities in timeliness of prenatal care. However, as **HAP Empowered** was unable to identify a disparity within its total membership, the MHP determined that the focus for the PIP is to improve timeliness of prenatal care for Black/African-American pregnant women as this population was the lowest-performing subgroup. While **HAP Empowered** made progress in improving the rate of Black/African American women

Performance Area	Overall Performance Impact
	receiving timely prenatal care, it did not achieve significant improvement over the baseline rate for the first remeasurement period. These results align with the results of the HEDIS audit documented within the 2023 HEDIS Aggregate Report for Michigan Medicaid located in Appendix B. While **HAP Empowered**'s rate for the *Timeliness of Prenatal Care* measure demonstrated some improvement from the prior year, it ranked below the 25th Medicaid Quality Compass percentile. These results indicate that many women are not receiving prenatal care within the first trimester. Prenatal care during the first trimester can lower the risk of pregnancy complications. Additionally, through its PIP, while **HAP Empowered** identified barriers and corresponding interventions, they appear to be generalized to the MHP's entire pregnant member population and not specific to its target population (i.e., Black/African-American pregnant members), which may have contributed to the minimal improvement in its performance indicator. **HAP Empowered** should ensure its PIP, including barriers and interventions, has a strong focus on its defined target population (i.e., identify barriers specifically for Black/African-American pregnant women and implement interventions that are tailored to Black/African-American pregnant women). Further, **HAP Empowered** met MDHHS' expectations for addressing health disparities through population health management as demonstrated by a 100 percent compliance score for the Quality standard and specifically a *Met* score for element *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*. **HAP Empowered** demonstrated it had adequate policies and procedures for providing population health management services. **HAP Empowered** should continue to conduct data analysis through its quality program to identify and subsequently implement interventions to reduce disparities in healthcare.
Preventive Care	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity demonstrated positive performance for the *Chlamydia Screening in Women* and *Breast Cancer Screening* measures, as the four rates for these measures ranked between the 50th and 74th or the 75th and 89th Medicaid Quality Compass percentiles. Further, all three rates for the *Chlamydia Screening in Women* measure demonstrated a statistically significant improvement from the prior year. According to the CDC, chlamydia can cause permanent damage to a woman's reproductive system and potentially fatal ectopic pregnancy. Because chlamydia usually has no symptoms, screening is necessary to identify and subsequently treat the infection. **HAP Empowered**'s PMV results confirm that many of its female members are being appropriately screened. Additionally, as demonstrated through the compliance review activity, **HAP Empowered** met MDHHS' expectations for monitoring appointment wait times for preventive services. Specifically, **HAP Empowered** received a *Met* score for element *2.10 Provider Wait Times* under the Providers standard, which included, but was not limited to, monitoring of the following metrics: *Routine Care is available within 30 Business Days of request*, *Routine Dental*

Performance Area	Overall Performance Impact
	Care is within 21 Business Days of request, and *Preventive Dental Services is within six weeks of request*. However, as demonstrated through the PMV activity, **HAP Empowered** has opportunities to increase the number of members receiving preventive services for well-care visits and cervical cancer screening. All rates for the *Well-Child Visits in the First 30 Months of Life*, *Child and Adolescent Well-Care Visits*, and *Cervical Cancer Screening* measures ranked below the 49th Medicaid Quality Compass percentile, with four of those rates ranking below the 25th percentile. While continued opportunities exist to improve access to well-care visits and preventive screenings, it should be noted that all rates for the *Well-Child Visits in the First 30 Months of Life*, *Child and Adolescent Well-Care Visits*, and *Cervical Cancer Screening* measures improved from the prior year, with three of those rates demonstrating statistically significant improvement. Preventive care and screenings can monitor growth and development, reduce the chance of obtaining a vaccine preventable condition, and lead to early detection of cancer. Therefore, **HAP Empowered** should continue its efforts to improve performance for these measures as they appear to have been successful. Additionally, the results of the NAV activity indicate that some of **HAP Empowered**'s members may be experiencing challenges making appointments with PCPs or pediatric providers due to inaccurate information within **HAP Empowered**'s provider directory, and provider offices informing members that they do not accept **HAP Empowered** Medicaid insurance. Further, of providers responding to the survey and accepting the insurance and new patients, only 26.1 percent and 72.5 percent of PCPs and pediatric providers, respectively, offered the caller an appointment. **HAP Empowered** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members. While the NAV activity identified opportunities for improvement, it should be noted that when callers were offered an appointment, all PCPs and most pediatric providers offered an appointment that met the MDHHS appointment timeliness standard of 30 business days. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged from 70.83 percent to 72.46 percent. **HAP Empowered** should also consider these results when determining potential barriers for members accessing preventive care due to dissatisfaction with their PCP. Lastly, **HAP Empowered** received a *Not Met* score for element *3.1 Member Material – ID Card and Member Handbook* under the Members standard within the compliance review activity, as a gap in the timely dissemination of member packets with ID cards and handbooks was identified by MDHHS. While this may not have directly impacted member outcomes, this may have

Performance Area	Overall Performance Impact
	resulted in a delay in some members receiving information on their assigned PCP and covered benefits, which in turn could cause a delay in members seeking care.
Care for Chronic Conditions	**Quality**, **Timeliness**, and **Access—**Overall, **HAP Empowered** demonstrated positive results through the PMV activity as the MHP's rates ranked between the 50th and 74th Medicaid Quality Compass percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1cPoor Control (>9.0%)*, *Blood Pressure Control for Patients With Diabetes*, *Kidney Health Evaluation for Patients With Diabetes* (all rates), and *Controlling High Blood Pressure* measures; and between the 75th and 89th percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *Eye Exam for Patients With Diabetes* measures. Further, **HAP Empowered** increased performance for all measure rates under the Living With Illness domain, with seven of those rates demonstrating statistically significant improvement. Appropriate management of chronic conditions can reduce symptoms and the chance of serious complications and improve quality of life. The results of the PMV suggest that **HAP Empowered** is making efforts to ensure positive outcomes for members diagnosed with diabetes and hypertension. Also, as demonstrated by a *Met* score for element *3.10 CSHCS PCP Requirements* under the Members standard within the compliance review activity, **Aetna Better Health of Michigan** met MDHHS' expectations for assignment of PCPs for children and youth with complex chronic conditions. However, the results of the NAV activity indicate that some of **HAP Empowered**'s members may be experiencing challenges making appointments with PCPs due to inaccurate provider directory information, and PCPs indicating they do not accept **HAP Empowered** Medicaid insurance or new patients. Further, of the offices responding to the survey and accepting **HAP Empowered** Medicaid insurance and new patients, only 26.1 percent of PCPs offered the caller an appointment. **HAP Empowered** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members. While the NAV activity identified opportunities for improvement, it should be noted that when callers were offered an appointment, all PCPs offered a timely appointment (i.e., within the 30 business days appointment standard established by MDHHS). Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged from 70.83 percent to 72.46 percent. **HAP Empowered** should also consider these results when determining potential barriers for members accessing care for chronic conditions that may be related to dissatisfaction with their provider.

Performance Area	Overall Performance Impact
	Lastly, **HAP Empowered** received a *Not Met* score for element *3.1 Member Material – ID Card and Member Handbook* under the Members standard within the compliance review activity, as a gap in the timely dissemination of member packets with ID cards and handbooks was identified by MDHHS. While this may not have directly impacted member outcomes, this may have resulted in a delay in some members receiving information on their assigned PCP and covered benefits, which in turn could cause a delay in members seeking care for their chronic conditions.
Health Information Systems and Technology	**Quality**, **Timeliness**, and **Access—HAP Empowered** demonstrated strengths of its health information systems and technology through the PMV, compliance, and EDV activities. The PMV findings confirmed that **HAP Empowered** was fully compliant with how it collected, stored, analyzed, and reported HEDIS data. All rates were *Reportable*, indicating that **HAP Empowered** followed the NCQA technical specifications for the calculation of HEDIS performance measures. Additionally, although **HAP Empowered** scored below the statewide average for the MIS/Financial standard within the compliance review activity, it received a score of 95 percent, indicating that it met MDHHS' expectations for most requirements pertaining to **HAP Empowered**'s MIS. Further, through the EDV activity, **HAP Empowered** demonstrated its capability to collect, process, and transmit encounter data to MDHHS; submit encounter data timely; and populate valid key data elements for all service categories. However, **HAP Empowered** modified encounters from its subcontractors before submitting them to MDHHS. To ensure the integrity of data is maintained, the MHP should consult with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractor. Additionally, as **HAP Empowered** did not report on any quality checks performed for claims/encounters from its laboratory subcontractor, **HAP Empowered** should develop a comprehensive suite of monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its subcontractor. Further, as approximately 24 percent of **HAP Empowered** pharmacy encounters had a submit date prior to the payment date, **HAP Empowered** should implement quality checks to ensure the submission date is after the payment date. Lastly, as demonstrated through the compliance review findings, **HAP Empowered** was not fully compliant with the *Submitted and accepted records must meet or exceed the minimum volume calculated by MDHHS* (related to pharmacy invoice types), and *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS* (related to dental invoice types) metrics under compliance review elements *5.14 Monthly Pharmacy Encounter Timeliness* and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. Therefore, **HAP Empowered** should continue to implement action plans and monitoring processes to ensure all claims processing performance standards are consistently met.

McLaren Health Plan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2023 evaluated the technical methods of **McLaren Health Plan**'s PIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG determined the overall methodological validity of the PIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-44 displays the overall validation rating, the baseline rate, Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-44—Overall Validation Rating for MCL

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities in Timeliness of Prenatal Care	*Met*	1. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for Black members.	60.8%	62.1% ⇔		Yes
		2. The percentage of deliveries that received a prenatal care visit as a member of an organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization for White members.	71.7%	71.9% ⇔		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MHP conducted accurate data analysis and interpretation of PIP results; overall confidence that the PIP produced significant evidence of improvement).

The goals for **McLaren Health Plan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-45 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-45—Remeasurement 1 Barriers and Interventions for MCL

Barriers	Interventions
Members are not obtaining prenatal care in a timely manner.	Targeted outreach to members in regions 6 and 7 (highest population and disparate areas) upon notification of pregnancy to facilitate timeliness of prenatal care.
OB providers not getting members into prenatal visits in a timely manner.	Providers received a $100 incentive for completing timely prenatal and postpartum care.
	Providers received monthly gaps-in-care reports with disparity information for this measure.
Members are not being identified early in their pregnancy.	Members received a $10 gift card incentive upon notification of pregnancy to the MHP.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: McLaren Health Plan initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality**, **Timeliness**, and **Access**]

Strength #2: McLaren Health Plan demonstrated clinically significant improvement over the baseline performance for the disparate population through the initiation of an intervention strategy. The intervention increased the number of providers receiving timely gaps-in-care reports with disparity data included. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period. [**Quality** and **Access**]

Why the weakness exists: While it is unclear why the goal was not achieved, **McLaren Health Plan** has made progress in improving performance for the disparate population.

Recommendation: HSAG recommends that **McLaren Health Plan** revisit its causal/barrier analysis to determine if any new barriers exist for the disparate population that require the development of targeted strategies to improve performance.

Performance Measure Validation

Performance Results

McLaren Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2022 Compliance Audit Report findings, **McLaren Health Plan** was fully compliant with all seven IS standards.

According to the auditor's review, **McLaren Health Plan** followed the NCQA HEDIS MY 2022 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-46 displays the MDHHS-selected performance measures, HEDIS MY 2021 and MY 2022 rates, MY 2021 and MY 2022 comparisons, and MY 2022 performance levels based on comparisons to national percentiles[3-26] for **McLaren Health Plan**. Additional performance measures and performance measure results for **McLaren Health Plan** can be referenced in Appendix B.

Table 3-46—HEDIS MY 2022 Performance Measure Results for MCL

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.66%	65.02%	+6.36+	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	59.04%	62.08%	+3.04+	★★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	54.63%	58.39%	+3.76+	★★★
Ages 12 to 17 Years	44.47%	47.20%	+2.73+	★★

[3-26] HEDIS MY 2022 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2021 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Ages 18 to 21 Years	23.41%	23.31%	-0.10	★★
Total	45.88%	48.46%	+2.58+	★★
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	53.84%	52.46%	-1.38	★★★
Ages 21 to 24 Years	61.89%	62.53%	+0.64	★★★
Total	57.84%	57.54%	-0.30	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	56.69%	55.06%	-1.63	★★
Breast Cancer Screening				
Breast Cancer Screening	53.67%	54.65%	+0.98	★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)**	54.74%	58.64%	+3.90	★
HbA1c Control (<8.0%)	38.20%	34.79%	-3.41	★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	50.61%	52.55%	+1.94	★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	43.31%	47.69%	+4.38	★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	29.11%	30.99%	+1.88+	★★
Ages 65 to 74 Years	42.42%	20.63%	-21.79++	★
Ages 75 to 85 Years	NA	NA	NC	NC
Total	29.22%	30.94%	+1.72+	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	45.26%	46.47%	+1.21	★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.
* For this indicator, a lower rate indicates better performance.
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: McLaren Health Plan's performance ranked between the 75th and 89th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, indicating children who turned 15 months old during the measurement year were getting at least six well-child visits with a PCP during their first 15 months of life most of the time. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-27] [**Quality**, **Timeliness**, and **Access**]

Strength #2: McLaren Health Plan demonstrated overall strength in its HEDIS data reporting, as **McLaren Health Plan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan's performance for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators ranked below the 25th percentile, indicating members with diabetes did not aways have controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-28] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators ranked below the 25th percentile. **McLaren Health Plan** noted barriers such as incorrect or missing contact information for members, which reduced successful member outreach.

Recommendation: While **McLaren Health Plan** noted several interventions currently in place to target improvement, such as distributing care gap reports to providers, which highlighted members with lower glycemic control, and offering monetary incentives to members for completed HbA1c testing, performance remains low for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators. Therefore, HSAG recommends that **McLaren Health Plan** continue its efforts to improve performance for the

[3-27] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

[3-28] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.

Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%) and *HbA1c Control (<8.0%)* measure indicators. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #2: McLaren Health Plan's performance for the *Blood Pressure Control for Patients With Diabetes* measure indicator ranked below the 25th percentile, indicating some members with diabetes did not have controlled blood pressure. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-29] [**Quality** and **Access**]

Why the weakness exists: While the rate for the *Blood Pressure Control for Patients With Diabetes* measure indicator demonstrated improvement from MY 2021 to MY 2022, the rate for the *Blood Pressure Control for Patients With Diabetes* measure ranked below the 25th percentile. A barrier noted by **McLaren Health Plan** was that, while a second blood pressure reading is best practice, a second blood pressure may not be taken if the initial reading was greater than 140/90 mmHg.

Recommendation: While **McLaren Health Plan** noted several interventions currently in place to target improvement, such as distributing care gap reports to providers to outline members with blood pressure readings greater than 140/90 mmHg and routine provider reminders on member incentives for accessing diabetes care, performance remains low for the *Blood Pressure Control for Patients With Diabetes* measure. Therefore, HSAG recommends that **McLaren Health Plan** continue its efforts to improve performance for the *Blood Pressure Control for Patients With Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #3: McLaren Health Plan's performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years* measure indicator ranked below the 25th percentile, a significant decline from the prior year. Additionally, performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure indicators ranked between the 25th and 49th percentile, indicating some members with a diagnosis of diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-30] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years* measure indicator ranked below the 25th percentile, a significant decline from the prior year. Additionally, performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure indicators ranked between the 25th and 49th percentile. A barrier noted by **McLaren Health Plan** was inconsistencies in how providers ordered and coded kidney tests.

Recommendation: While **McLaren Health Plan** noted several interventions currently in place to target improvement, such as provider education, distributing care gap reports to providers, offering member incentives, partnering with community health workers (CHWs) to address member access to

[3-29] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.

[3-30] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Mar 7, 2024.

care barriers, and implementing a new texting campaign to assist members with gaps in care and obtaining needed resources, performance remains low for the *Kidney Health Evaluation for Patients With Diabetes* measure. Therefore, HSAG recommends that **McLaren Health Plan** continue its efforts to improve performance for the *Kidney Health Evaluation for Patients With Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #4: McLaren Health Plan's performance for the *Controlling High Blood Pressure* measure ranked below the 25th percentile, indicating some members with a diagnosis of hypertension did not have controlled blood pressure. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-31] [**Quality** and **Access**]

Why the weakness exists: While the rate for the *Controlling High Blood Pressure* measure demonstrated improvement from MY 2021 to MY 2022, the rate for the *Controlling High Blood Pressure* measure ranked below the 25th percentile. A barrier noted by **McLaren Health Plan** was that, while a second blood pressure reading is best practice, a second blood pressure may not be taken if the initial reading was greater than 140/90 mmHg.

Recommendation: While **McLaren Health Plan** noted several interventions currently in place to target improvement, such as distributing care gap reports to providers to outline members with blood pressure readings greater than 140/90 mmHg, routine provider reminders, and member outreach through community health partnerships, performance remains low for *Controlling High Blood Pressure* measure. Therefore, HSAG recommends that **McLaren Health Plan** continue its efforts to improve performance for the *Cervical Cancer Screening* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #5: McLaren Health Plan's performance for the *Cervical Cancer Screening* measure ranked between the 25th and 49th percentile, indicating women were not always being screened for cervical cancer. Cervical cancer is one of the most common causes of cancer death for American women; effective screening and early detection of cervical pre-cancers have led to a significant reduction in this death rate.[3-32] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Cervical Cancer Screening* measure ranked between the 25th and 49th percentile. **McLaren Health Plan** noted barriers such as incorrect or missing contact information for members, which reduced successful member outreach.

Recommendation: While **McLaren Health Plan** noted several interventions currently in place to target improvement, such as ensuring providers had reports on member gaps in recommended services, member education on the importance of preventative screenings, provider education, and texting campaigns, performance remains low for the *Cervical Cancer Screening* measure. Therefore, HSAG recommends that **McLaren Health Plan** continue its efforts to improve performance for the

3-31 National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Mar 7, 2024.
3-32 National Committee for Quality Assurance. Cervical Cancer Screening (CCS). Available at: https://www.ncqa.org/hedis/measures/cervical-cancer-screening/. Accessed on: Mar 7, 2024.

Cervical Cancer Screening measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified. **McLaren Health Plan** could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints.

Compliance Review

Performance Results

Table 3-47 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, *or Not Met*. Table 3-47 also presents **McLaren Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. **McLaren Health Plan** was subject to a corrective action review process outlined in Appendix A.

Table 3-47—Compliance Review Results for MCL

Standard		Number of Scores			Compliance Scores	
		Met	*Satisfied*[1]	*Not Met*	MCL[2]	Statewide[3]
1	Administrative	5	0	0	100%	100%
2	Providers	22	0	1	96%	94.7%
3	Members	27	0	2	93%	97.7%
4	Quality	22	0	0	100%	99.5%
5	MIS/Financial	38	0	2	95%	96.1%
6	OIG/Program Integrity	33	0	2	94%	90.2%
Overall		**147**	**0**	**7**	**95%**	**95.5%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

[2] MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

[3] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **McLaren Health Plan** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the

compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: McLaren Health Plan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: McLaren Health Plan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs; QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: While **McLaren Health Plan** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for elements *3.1 Member Material – ID Card and Member Handbook* and *3.6-A Member Appeals*. [**Timeliness** and **Access**]

Why the weakness exists: There was no indication the member packets with ID cards and handbooks were mailed within 10 business days of notification of enrollment. While the MHP reported that it provides members with access to an electronic copy of the member handbook online via the new member welcome letter that is mailed within 10 days, this process was not communicated to MDHHS during the initial submission. Additionally, **McLaren Health Plan** had multiple standard and expedited appeals that were not resolved timely with no explanation. The MHP reported that it had implemented a new electronic system for appeals; however, there were challenges with implementation and the reporting and tracking of timeliness within the system. The MHP also reported that some appeals were miscategorized due to human error, which led to missed deadlines.

Recommendation: McLaren Health Plan was required to submit a CAP to address elements 3.1 and 3.6-A, which were approved by MDHHS. As such, HSAG recommends that **McLaren Health Plan** continue to implement action plans and monitoring processes to ensure members are provided access to the member handbook timely and that all appeals are resolved timely.

Weakness #2: While **McLaren Health Plan** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *5.1 Health Plan Maintains an Information System that Collects, Analyzes, Integrates and Reports Data as Required by MDHHS* and *5.14 Monthly Pharmacy Encounter Timeliness*. [**Quality** and **Timeliness**]

Why the weakness exists: **McLaren Health Plan** failed to submit the required operational plan and screen prints for claims processing, and screen prints for grievance and appeal tracking; and MDHHS was unable to locate documentation supporting that assignment to a PCP occurs within one month if member does not choose a PCP at the time of enrollment. The MHP's submission was insufficient, unclear, or missing documentation. Additionally, **McLaren Health Plan** did not meet pharmacy timeliness requirements for encounters paid for one reporting month nor provided a narrative explanation of why timeliness requirements were not met. The MHP reported that there was an abnormally higher volume of pharmacy encounters submitted for the prior month and in the following two months, there were higher volumes due to seasonality. The MHP further indicated that such swings in volume can occur from time to time.

Recommendation: **McLaren Health Plan** was required to submit a CAP to address elements 5.1 and 5.14, which were approved by MDHHS. As such, HSAG recommends that **McLaren Health Plan** continue to implement action plans and monitoring processes to ensure adherence to IS and encounter processing requirements (i.e., *Operational plan and screen prints for claims processing, grievance and appeals tracking, and assignment to PCP* and *Encounter submissions must be submitted by the 15th of the month following the month of payment*).

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 307 cases by comparing provider data that **McLaren Health Plan** submitted to HSAG against **McLaren Health Plan**'s online provider directory. The sample included 153 PCPs, 153 pediatric providers, and one OB/GYN providers (Table 3-48). For SFY 2023, the eligible population criteria were updated to limit to those providers with the PCP indicator, which reduced the number of eligible OB/GYN providers. Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 91.5 percent (n=281) of the reviews. The sampled providers were not found in the online provider directory in 8.5 percent (n=26) of the reviewed cases.

Table 3-48—Summary of Providers Present in the Directory by Provider Category

		Providers Found in Directory		Providers Not Found in Directory	
Provider Category	Number of Sampled Providers	Count	%	Count	%
PCPs	153	134	87.6%	19	12.4%
Pediatric Providers	153	146	95.4%	7	4.6%
OB/GYN Providers	1	1	100%	0	0.0%
MCL Total	**307**	**281**	**91.5%**	**26**	**8.5%**

Table 3-49 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **McLaren Health Plan**'s provider data submission to HSAG and **McLaren Health Plan**'s online provider directory.

Table 3-49—Provider Demographic Indicators Matching Online Provider Directory

	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%	Count	%
Provider's Name	134	100%	146	100%	1	100%	281	100%
Provider Street Address	132	98.5%	145	99.3%	1	100%	278	98.9%
Provider Suite Number	134	100%	146	100%	1	100%	281	100%
Provider City	133	99.3%	144	98.6%	1	100%	278	98.9%
Provider State	134	100%	146	100%	1	100%	281	100%
Provider ZIP Code	133	99.3%	146	100%	1	100%	280	99.6%
Provider Telephone Number	133	99.3%	145	99.3%	1	100%	279	99.3%
Provider Type/Specialty	134	100%	145	99.3%	1	100%	280	99.6%
Provider Accepting New Patients	133	99.3%	145	99.3%	1	100%	279	99.3%
Provider Gender	133	99.3%	146	100%	1	100%	280	99.6%
Provider Primary Language*	134	100%	142	97.3%	0	0.0%	276	98.2%
Non-English Language Speaking Provider (including American Sign Language)*	48	35.8%	145	99.3%	1	100%	194	69.0%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 274 sampled provider locations (i.e., "cases") for **McLaren Health Plan**, with an overall response rate of 59.1 percent (n=162). Table 3-50 summarizes the secret shopper survey results for **McLaren Health Plan**.

Table 3-50—Summary of MCL Secret Shopper Survey Results

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
PCPs	132	78	59.1%	48	61.5%	46	59.0%	33	42.3%	27	34.6%
Pediatric Providers	141	83	58.9%	54	65.1%	51	61.4%	20	24.1%	17	20.5%
OB/GYN Providers	1	1	100%	1	100%	1	100%	0	0.0%	0	0.0%
MCL Total	**274**	**162**	**59.1%**	**103**	**63.6%**	**98**	**60.5%**	**53**	**32.7%**	**44**	**27.2%**

Table 3-51 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **McLaren Health Plan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-51—Appointment Availability Results

			Cases Offered an Appointment			Appointment Wait Time (Days)				
Provider Category	Total Survey Cases	Cases Accepting New Patients	Count	Rate Among All Surveyed Cases[1] (%)	Rate Among Cases Accepting New Patients[2] (%)	Min	Max	Average	Median	Percentage of Cases Within Standard[3]
PCPs	132	23	23	17.4%	100%	0	44	15	11	91.3%
Pediatric Providers	141	13	10	7.1%	76.9%	10	85	31	20	70.0%
OB/GYN Providers	1	0	0	0.0%	NA*	--	--	--	--	--
MCL Total	**274**	**36**	**33**	**12.0%**	**91.7%**	**0**	**85**	**19**	**13**	**84.8%**

[1] The denominator includes all surveyed cases included in the sample.
[2] The denominator includes cases responding to the survey that accept the insurance and new patients.
[3] The denominator includes cases offered an appointment. The MDHHS appointment timeliness standards are 30 business days for routine care appointments and seven business days for prenatal care appointments.
NA* indicates that cases responding to the survey did not accept new patients.
-- Indicates that appointment wait time and compliance standards were not evaluated due to no cases accepting new patients.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Reviewers located over 91 percent of the sampled providers in **McLaren Health Plan**'s online provider directory. Of the providers that reviewers located in the online directory, 11 of 12 indicators had a match rate above 98 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 59.1 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **McLaren Health Plan**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **McLaren Health Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of the locations reached, only 63.6 percent confirmed affiliation with the sampled provider. Additionally, 60.5 percent confirmed accuracy of the sampled address, 32.7 percent confirmed the services were offered, and 27.2 percent confirmed the requested insurance was accepted. [**Quality** and **Access**]

Why the weakness exists: **McLaren Health Plan**'s provider data included invalid provider, specialty, and insurance information.

Recommendation: HSAG recommends that **McLaren Health Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

Encounter Data Validation

Performance Results

Representatives from **McLaren Health Plan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **McLaren Health Plan**'s original questionnaire responses, and **McLaren Health Plan** responded to these specific questions. To support its questionnaire responses, **McLaren Health Plan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **McLaren Health Plan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-52 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-52—EDV Results for MCL

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• For medical claims, **McLaren Health Plan** utilized Optum Clearinghouse and Health Edge (Health Rules Manager) as its primary software for claim adjudication and encounter preparation. For dental claims, it used Sterling Integrator. • **McLaren Health Plan** had processes in place to detect and identify duplicate claims. **McLaren Health Plan** clarified that it did not submit claims that lacked member eligibility and services that were deemed invalid. In cases requiring adjustments, the claim frequency code "7" was used to indicate an adjusted encounter. • **McLaren Health Plan** and its subcontractors were responsible for collecting and maintaining provider information. Additionally, **McLaren Health Plan** managed enrollment data received from MDHHS through 834 files, providing daily Medicaid enrollment updates to the MHPs for integration into their claim processing systems. **McLaren Health Plan** ensured that subcontractors also received and incorporated these enrollment details into their respective claim systems.

Analysis	Key Findings
Payment Structures	• **McLaren Health Plan** utilized various claim payment methods for different encounter types. In inpatient encounters, it employed line-by-line, variable per diem, and DRG methods. For outpatient encounters, the methods included line-by-line, variable per diem, and capitation. Pharmacy encounters were processed using the ingredient cost method. • In general, **McLaren Health Plan** processed claims with TPL based on the collected insurance coverage information. When a claim suggests the existence of additional primary insurance for a member, the MHP's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details.
Encounter Data Quality Monitoring	• **McLaren Health Plan** indicated it edited or made modifications to its dental subcontractor data. • **McLaren Health Plan** and/or its subcontractors performed several data quality checks on the encounter data collected by the subcontractors. These checks included, but were not limited to, analyzing claim volume by submission month (for laboratory and pharmacy), assessing field-level completeness and validity (for dental and laboratory), evaluating timeliness (laboratory encounters), and ensuring alignment between payment fields in claims and financial reports (for dental encounters). • For encounters collected by **McLaren Health Plan**, it conducted claim volume by submission month, EDI compliance edit checks, field-level completeness and validity, and quarterly encounter acceptance compliance review.
Administrative Profile	
Encounter Data Completeness	• **McLaren Health Plan** displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • **McLaren Health Plan** had a low volume of duplicate encounters, with less than 0.1 percent of professional encounters, less than 0.1 percent of institutional encounters, 0.7 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative.
Encounter Data Timeliness	• **McLaren Health Plan** demonstrated timely submission of professional, institutional, dental, and pharmacy encounters. Within 30 days, **McLaren Health Plan** submitted 99.2 percent of professional encounters to MDHHS after the payment date, and within 90 days, it submitted 99.0 percent of institutional

Analysis	Key Findings
	encounters to MDHHS after the payment date. Within 60 days, **McLaren Health Plan** submitted 99.8 percent of dental encounters and 99.7 percent of pharmacy encounters to MDHHS after the payment date. • **McLaren Health Plan**'s submitted data contained a missing paid or submission date for less than 0.1 percent of pharmacy encounters.
Field-Level Completeness and Accuracy	• All data elements in **McLaren Health Plan**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **McLaren Health Plan**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the enrollment data. • Of all identified member IDs in **McLaren Health Plan**'s submitted pharmacy data, 99.9 percent were identified in the enrollment data. • Of all identified provider NPIs in **McLaren Health Plan**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. • Of all identified provider NPIs in **McLaren Health Plan**'s submitted pharmacy encounter data, 95.0 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **McLaren Health Plan**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: McLaren Health Plan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The MHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: McLaren Health Plan submitted professional, institutional, dental, and pharmacy encounters in a timely manner from the payment date, with about 99 percent of all encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all categories of service, key data elements for **McLaren Health Plan** were populated at high rates and generally greater than 95 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan modified encounters from its subcontractors before submitting them to MDHHS. [**Quality**]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: McLaren Health Plan should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: McLaren Health Plan only indicated it performed encounter claim volume quality checks for claims/encounters from its pharmacy subcontractor. [**Quality**]

Why the weakness exists: Ensuring data accuracy, completeness, and timeliness requires the implementation of claims/encounter quality checks.

Recommendation: McLaren Health Plan should develop a comprehensive suite of monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its subcontractor.

Weakness #3: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 95 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: McLaren Health Plan should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-53 presents **McLaren Health Plan**'s 2022 and 2023 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-53—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for MCL

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Global Ratings				
Rating of Health Plan	59.57%	63.35%	62.74%	71.43% ▲
Rating of All Health Care	58.06%	57.14%	70.73%	59.44% ▼↓
Rating of Personal Doctor	69.50%	65.41%	71.66%	74.78%
Rating of Specialist Seen Most Often	62.22%+	56.04%+ ↓	62.50%+	74.70%+
Composite Measures				
Getting Needed Care	85.28%	87.78% ↑	86.06%+	88.13%
Getting Care Quickly	85.43%	87.87% ↑	90.69%+	89.75%
How Well Doctors Communicate	94.15%	92.11%	95.01%	94.20%
Customer Service	87.13%+	88.34%+	94.32%+	90.38%+
Individual Item Measure				
Coordination of Care	85.06%+	83.95%+	76.36%+	83.72%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	70.72%	72.05%	—	—
Discussing Cessation Medications	50.00%	50.31%	—	—
Discussing Cessation Strategies	43.89%	46.54%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: McLaren Health Plan's 2023 top-box score was statistically significantly higher than the 2022 child Medicaid top-box score for one measure, *Rating of Health Plan*. [**Quality**]

Strength #2: **McLaren Health Plan**'s 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for two measures: *Getting Needed Care* and *Getting Care Quickly*. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average and the 2022 child Medicaid top-box score for one measure, *Rating of All Health Care*. [**Quality**]

Why the weakness exists: When compared to national benchmarks and the previous year's top-box scores, the results indicate that parents/caretakers of child members enrolled in **McLaren Health Plan** are reporting a more negative experience with their child's healthcare since the score for this measure was statistically significantly below the 2022 NCQA child Medicaid national average and 2022 child Medicaid top-box score. The MHP previously reported that the CAHPS surveys are de-identified and absent of any specific information to be able to assist members facing challenges with the MHP. Outreach efforts are provided to the general population based on results; however, responses may be an individual experience or concern that the MHP is unable to directly impact. The MHP is hopeful that the possible addition of member-specific surveys completed at the time of interaction will help drill down to specific areas or concerns that currently CAHPS does not allow.

Recommendation: HSAG recommends that **McLaren Health Plan** continue to explore what may be driving these lower experience scores, develop initiatives designed to improve quality of care, and focus on improving members' overall experiences with their healthcare.

Weakness #2: McLaren Health Plan's 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for one measure, *Rating of Specialist Seen Most Often*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate that **McLaren Health Plan**'s members are reporting a more negative experience with their specialist. The MHP previously reported that the CAHPS surveys are de-identified and absent of any specific information to be able to assist members facing challenges with the MHP. Outreach efforts are provided to the general population based on results; however, responses may be an individual

experience or concern that the MHP is unable to directly impact. The MHP is hopeful that the possible addition of member-specific surveys completed at the time of interaction will help drill down to specific areas or concerns that currently CAHPS does not allow.

Recommendation: HSAG recommends that **McLaren Health Plan** determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the plan that could be contributing to a lack of network adequacy and access issues. HSAG further recommends that the MHP continue to explore the option of conducting other MHP-specific member experience surveys that allow the MHP to better understand member-specific experiences and target areas where members express a negative experience.

Performance Results—CSHCS

Table 3-54 presents **McLaren Health Plan**'s 2022 and 2023 CSHCS CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-54—Summary of CSHCS CAHPS Survey Top-Box Scores for MCL

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	69.71%	68.64%
Rating of Health Care	73.47%	72.02% NA
Rating of Specialist Seen Most Often	75.78%	78.65%
Rating of CMDS Clinic	63.16%+	79.49%+ NA
Composite Measures		
Customer Service	87.88%+	95.95%+ NA
How Well Doctors Communicate	95.50%	95.44% NA
Access to Specialized Services	76.53%+	72.03%+ NA
Transportation	78.63%+	82.05%+ NA
Individual Item Measures		
Access to Prescription Medicines	94.02%	89.39%
CMDS Clinics	79.49%+	90.00%+ NA
Local Health Department Services	77.22%+	78.82%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	96.74%	99.49% NA
Not Felt Treated Unfairly: Health Insurance Type	92.43%	95.41% NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.

▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: McLaren Health Plan's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.
Why the weakness exists: NA
Recommendation: HSAG recommends that **McLaren Health Plan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-55 presents **McLaren Health Plan**'s 2022 and 2023 HMP CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher than the 2022 scores.

Table 3-55—Summary of HMP CAHPS Top-Box Scores for MCL

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	62.04%	59.19%
Rating of All Health Care	50.00%	56.72%
Rating of Personal Doctor	63.64%	60.92% ↓
Rating of Specialist Seen Most Often	58.02%+	62.20%+

	2022 Top-Box Score	2023 Top-Box Score
Composite Measures		
Getting Needed Care	84.92%	89.52% ↑
Getting Care Quickly	76.44%+	81.13%+
How Well Doctors Communicate	91.86%	89.68%
Customer Service	89.29%+	86.98%+
Individual Item Measure		
Coordination of Care	76.92%+	81.16%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	72.96%	73.08%
Discussing Cessation Medications	50.31%	48.46%
Discussing Cessation Strategies	42.50%	41.98%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.

Strengths, Weaknesses, and Recommendations—HMP

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: McLaren Health Plan's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Getting Needed Care* [**Quality** and **Access**].

Weaknesses and Recommendations

Weakness #1: McLaren Health Plan's 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for one measure, *Rating of Personal Doctor* [**Quality**].

Why the weakness exists: When compared to national benchmarks, the results indicate that **McLaren Health Plan**'s members are reporting a more negative experience with their personal doctor. The MHP previously reported that the CAHPS surveys are de-identified and absent of any specific information to be able to assist members facing challenges with the MHP. Outreach efforts are provided to the general population based on results; however, responses may be an individual experience or concern that the MHP is unable to directly impact. The MHP is hopeful that the possible addition of member-specific surveys completed at the time of interaction will help drill down to specific areas or concerns that currently CAHPS does not allow.

Recommendation: HSAG recommends that **McLaren Health Plan** include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for the HMP members. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Physicians could ask questions about members' concerns, priorities, and values and listen to their answers. Also, physicians could check for understanding, while reinforcing key messages, by allowing members to repeat back what they understand about their conditions and the actions they will take to monitor and manage their conditions.

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide, which is inclusive of **McLaren Health Plan**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **McLaren Health Plan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **McLaren Health Plan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **McLaren Health Plan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-56 displays each applicable performance area and the overall performance impact related to the quality, timeliness, and accessibility of healthcare services provided to **McLaren Health Plan**'s Medicaid members.

Table 3-56—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access—McLaren Health Plan** continued its MDHHS-mandated PIP focused on addressing disparities in timeliness of prenatal care. **McLaren Health Plan** demonstrated clinically significant improvement over the baseline performance for the disparate subgroup (Black subgroup) through the initiation of an intervention strategy that increased the number of providers receiving timely gaps-in-care reports with disparity data included. Additionally, through its PIP, **McLaren Health Plan** identified barriers and corresponding interventions, which targeted outreach to members in regions 6 and 7 (i.e., highest population and disparate areas) upon notification of pregnancy to facilitate timeliness of prenatal care, which may have contributed to **McLaren Health Plan** demonstrating a slight improvement over the baseline performance for the disparate group. Further, **McLaren Health Plan** met MDHHS' expectations for addressing health disparities through population health management as demonstrated by a 100 percent compliance score for the Quality standard and specifically a *Met* score for element *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*. **McLaren Health Plan** demonstrated that it had adequate policies and procedures for providing population health management services. **McLaren Health Plan** should continue to conduct data analysis through its quality program to identify and subsequently implement interventions to reduce disparities in healthcare. However, **McLaren Health Plan** did not achieve the state-specific goal of eliminating the existing disparity through the PIP activity for the first remeasurement period. These results align with the results of the HEDIS audit documented within the 2023 HEDIS Aggregate Report for Michigan Medicaid in Appendix B as **McLaren Health Plan** demonstrated a decline of 6 percentage points from the prior year for *Timeliness of Prenatal Care* rate and ranked below the 25th Medicaid Quality Compass percentile. These results indicate that many women are not receiving prenatal care within the first trimester. Prenatal care during the first trimester can lower the risk of pregnancy complications.
Preventive Care	**Quality**, **Timeliness**, and **Access**—The results from the PMV activity demonstrated positive performance as it relates to preventive care and the *Chlamydia Screening in Women* and *Breast Cancer Screening* measures. All four rates for these measures ranked between the 50th and 74th Medicaid Quality Compass percentile. Routine health screenings for cancer and sexually transmitted diseases are essential to contributing to long-term positive health outcomes for members. Additionally, the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* ranked between the 75th and 89th percentile and the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years* ranked between the 50th and 74th Medicaid Quality Compass percentile. Further, five of the six rates for the *Well-Child Visits in the First 15 Month* and *Child and Adolescent Well-Care Visits* demonstrated a statistically significant

Performance Area	Overall Performance Impact
	increase from the prior year rates, indicating the MHP is making progress in increasing the number of children and adolescent members who are being seen regularly by a physician as recommended. Further, as demonstrated through the compliance review activity, **McLaren Health Plan** met MDHHS' expectations for monitoring appointment wait times for preventive services. Specifically, **McLaren Health Plan** received a *Met* score for element *2.10 Provider Wait Times* under the Providers standard, which included, but was not limited to, monitoring of the following metrics: *Routine Care is available within 30 Business Days of request*, *Routine Dental Care is within 21 Business Days of request*, and *Preventive Dental Services is within six weeks of request*. However, as demonstrated through the PMV activity, **McLaren Health Plan** also has opportunities to increase the number of members receiving preventive services through well-care visits and certain screenings. *Cervical Cancer Screening, Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, and three of the four measure rates for *Child and Adolescent Well-Care Visits* ranked between the 25th and 49th Medicaid Quality Compass percentile, indicating that fewer of the MHP's members received timely well-child visits for age-appropriate assessments, screenings, and counseling. Preventive care and screenings can monitor growth and development and reduce the chance of obtaining a vaccine preventable condition. Therefore, **McLaren Health Plan** should continue its efforts to improve performance for these measures. The results of the NAV activity indicated that some of **McLaren Health Plan**'s members may be experiencing challenges contacting or scheduling appointments with PCPs or pediatric providers due to inaccurate information within **McLaren Health Plan**'s provider directory and provider offices informing members that they do not accept **McLaren Health Plan** Medicaid insurance. **McLaren Health Plan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members. While 100 percent of PCPs offered an appointment with 91.3 percent offering a timely appointment in accordance with the MDHHS' standard, only 76.9 percent of pediatric providers offered an appointment, with only 70 percent of the pediatric providers offering a timely appointment in accordance with MDHHS' standard of 30 business days. To assist in improving more timely pediatric appointments, **McLaren Health Plan** should use the NAV results to educate pediatric providers on the appointment timeliness requirements. Additionally, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid populations did not demonstrate a statistically significant higher or lower score from its prior year or to the national average, the rates were 65.41 and 74.78 percent, respectively. However, for the HMP population, **McLaren Health Plan** demonstrated a statistically significant lower score from the prior year for *Rating of Personal Doctor*. As such,

Performance Area	Overall Performance Impact
	McLaren Health Plan should also consider these CAHPS results when determining potential barriers for members accessing preventive care due to dissatisfaction with their PCP.
Care for Chronic Conditions	**Quality**, **Timeliness**, and **Access—McLaren Health Plan**'s rate for *Eye Exam for Patients with Diabetes* measure ranked between the 50th to 74th Medicaid Quality Compass percentile, indicating many members diagnosed with diabetes are receiving eye exams as required. Additionally, as demonstrated by a *Met* score for element *3.10 CSHCS PCP Requirements* under the Members standard within the compliance review activity, **McLaren Health Plan** met MDHHS' expectations for assignment of PCPs for children and youth with complex chronic conditions. However, **McLaren Health Plan** overall, demonstrated lower performing results as noted through the PMV activity within the Living With Illness domain as five of the eight applicable rates ranked below the 25th Medicaid Quality Compass percentile, and two of the eight applicable rates ranked between the 25th to 49th Medicaid Quality Compass percentile. The rate for the *Kidney Health Evaluation for Patients With Diabetes-Ages 65 to 74 years* measure also demonstrated a statistically significant decline of 21.79 percentage points from the prior year. **McLaren Health Plan**'s PMV results indicate that opportunities for improvement exist for the management of chronic conditions. Appropriately managing chronic conditions can reduce symptoms and the chance of serious complications, and improve quality of life. Additionally, results of the NAV activity indicated that some of **McLaren Health Plan**'s members may be experiencing challenges making appointments with PCPs due to due to PCPs indicating that they do not accept **McLaren Health Plan** Medicaid insurance. **McLaren Health Plan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members, specifically related to whether the provider accepts the insurance. The CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average; however, the rates were 65.41 percent and 74.78 percent, respectively. Additionally, for the HMP population, **McLaren Health Plan** demonstrated a statistically significant lower score from the prior year. As such, **McLaren Health Plan** should also consider these CAHPS results when determining potential barriers for members accessing care for chronic conditions.

Performance Area	Overall Performance Impact
Health Information Systems and Technology	**Quality**, **Timeliness**, and **Access**—**McLaren Health Plan** demonstrated strengths of its health information systems and technology through the PMV, compliance, and EDV activities. The PMV findings confirmed that **McLaren Health Plan** was fully compliant with how it collected, stored, analyzed, and reported HEDIS data. All rates were *Reportable*, indicating that **McLaren Health Plan** followed the NCQA technical specifications for the calculation of HEDIS performance measures, and no rates were determined to be materially biased. Additionally, although **McLaren Health Plan** scored below the statewide average for the MIS/Financial standard within the compliance review activity, it received a score of 95 percent, indicating that it met MDHHS' expectations for most requirements pertaining to **McLaren Health Plan**'s MIS. Further, through the EDV activity, **McLaren Health Plan** demonstrated its capability to collect, process, and transmit encounter data to MDHHS; submit encounter data timely; and populate valid key data elements for all service categories. However, the EDV results identified that modifications to the subcontractor's encounters occurred without communicating the changes to the subcontractors. As such, **McLaren Health Plan** should collaborate with MDHHS to confirm that modifications to subcontractors' encounters do not require that the adjustments be sent back to the subcontractors. Additionally, **McLaren Health Plan** indicated that encounter claim volume quality checks for claims/encounters were only performed for its pharmacy subcontractor. **McLaren Health Plan** should consider adding monitoring reports to further evaluate encounter data accuracy, completeness, and timeliness for encounters. Also, as less pharmacy provider NPIs were identified in provider data than medical and dental provider NPIs, **McLaren Health Plan** should also collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers. Lastly, as demonstrated through the compliance review, **McLaren Health Plan** was not fully compliant with the *required operational plan and screen prints for claims payment; grievance and appeals tracking; and assignment to PCP within one month if member does not choose a PCP at the time of enrollment* under compliance review element *5.1 Health Plan Maintains an Information System that Collects, Analyzes, Integrates and Reports Data as Required by MDHHS.* Additionally, **McLaren Health Plan** did not meet pharmacy timeliness requirements for encounters paid for one reporting month or provide a narrative explanation of why timeliness requirements were not met under compliance review element *5.14 Monthly Pharmacy Encounter Timeliness*. Therefore, **McLaren Health Plan** should continue to implement action plans and monitoring processes to ensure all MIS-related performance standards are consistently met.

Meridian Health Plan of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2023 evaluated the technical methods of **Meridian Health Plan of Michigan**'s PIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG determined the overall methodological validity of the PIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-57 displays the overall validation rating, the baseline rate, Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-57—Overall Validation Rating for MER

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities for Timeliness of Prenatal Care: Addressing Racial Health Disparities	*Met*	1. Improve the PPC-Timeliness of Prenatal Care rate for the Black (non-Hispanic) population residing in Region 6 in order to reduce the disparity to the comparison subgroup.	61.9%	53.1% ⇔		Yes
		2. Maintain the performance of the HEDIS PPC-Timeliness of Prenatal Care performance result for eligible White (non-Hispanic) members residing in Region 6.	70.1%	62.8% ↓		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MHP conducted accurate data analysis and interpretation of PIP results; overall confidence that the PIP produced significant evidence of improvement.)

The goals for **Meridian Health Plan of Michigan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant

improvement as a result of an intervention. Table 3-58 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-58—Remeasurement 1 Barriers and Interventions for MER

Barriers	Interventions
Members lack awareness of the importance of early and adequate prenatal care and associated resources to attain prenatal care.	The MHP's Member Services department outreaches to members due for HEDIS PPC-Timeliness of Prenatal Care services telephonically to provide education and awareness, and to offer care coordination assistance. The Member Services department ensures members connect to care by helping members locate providers, schedule appointments, and arrange for transportation when needed or requested by members.
	The MHP to offer a member gift card incentive to members due for prenatal care visits after the member satisfactorily meets measure compliance.
	The MHP to incentivize members for self-reporting pregnancies to plan for care coordination and SDOH needs assessment.
Providers miss initiating timely prenatal care per the PPC HEDIS measure specifications. Providers may not be aware of members' pregnancy. Providers may have limited availability to accommodate timely prenatal care visits.	Providers are incentivized for successful completion of HEDIS PPC-Timeliness of Prenatal Care measure. The MHP publishes PPC HEDIS care gap reports and education to the providers for any members due for measure completion.
Coronavirus disease 2019 (COVID-19): Members experience vaccine hesitancy, misinformation, and virus contraction concerns. The MHP's Medicaid members have proven to be difficult to reach and transient at times. Members lack awareness of the importance of early and adequate prenatal care and access to attain prenatal care.	The MHP to refer Region 6 pregnant members due for prenatal care visits to CHWs for intensive outreach and engagement.
Structural and social determinants of health impede care.	The MHP to refer pregnant members to a group-based care program. Group prenatal care aims to educate women about pregnancy and childbirth in a group setting, with the goal of empowering patients to take control of their own health.
	Start Smart for Baby maternity case management program (SSFB). SSFB is an evidenced-based program that leverages advanced analytics to identify and engage members to improve obstetrical and pediatric care services and to reduce pregnancy-related complications, premature deliveries, low birth weight deliveries, and infant disease.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan of Michigan initiated interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Meridian Health Plan of Michigan demonstrated programmatically significant improvement over the baseline performance through the initiation of an intervention strategy. The intervention referred pregnant members due for prenatal care visits to CHWs for intensive outreach and engagement. [**Quality**, **Access**, and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period, with both performance indicators demonstrating a decrease in performance as compared to the baseline. [**Quality**, **Access,** and **Timeliness**]

Why the weakness exists: It is unclear why the state-defined goal was not met or the performance indicators declined in performance; however, the MHP initiated several intervention strategies late in the measurement period which may not have had time to impact the first remeasurement period.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance. Interventions should be initiated early in the measurement period to have the greatest impact on the performance indicators.

Performance Measure Validation

Performance Results

Meridian Health Plan of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2022 Compliance Audit Report findings, **Meridian Health Plan of Michigan** was fully compliant with all seven IS standards.

According to the auditor's review, **Meridian Health Plan of Michigan** followed the NCQA HEDIS MY 2022 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-59 displays the MDHHS-selected performance measures, HEDIS MY 2021 and MY 2022 rates, MY 2021 and MY 2022 comparisons, and MY 2022 performance levels based on comparisons to national percentiles[3-33] for **Meridian Health Plan of Michigan**. Additional performance measures and performance measure results for **Meridian Health Plan of Michigan** can be referenced in Appendix B.

Table 3-59—HEDIS MY 2022 Performance Measure Results for MER

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	60.85%	55.37%	**-5.48^{++}**	★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	61.93%	59.29%	**-2.64^{++}**	★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	58.18%	59.96%	+1.78^{+}	★★★
Ages 12 to 17 Years	49.86%	51.05%	+1.19^{+}	★★★
Ages 18 to 21 Years	27.39%	27.32%	-0.07	★★★
Total	50.75%	51.78%	+1.03^{+}	★★★
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	55.97%	61.07%	+5.10^{+}	★★★★
Ages 21 to 24 Years	64.36%	70.85%	+6.49^{+}	★★★★★
Total	59.89%	65.64%	+5.75^{+}	★★★★

[3-33] HEDIS MY 2022 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2021 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cervical Cancer Screening				
Cervical Cancer Screening	56.83%	60.34%	+3.51	★★★
Breast Cancer Screening				
Breast Cancer Screening	50.97%	53.52%	+2.55+	★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)**	52.07%	38.93%	-13.14+	★★★
HbA1c Control (<8.0%)	40.63%	54.99%	+14.36+	★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	51.34%	55.23%	+3.89	★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	55.72%	67.88%	+12.16+	★★★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	30.15%	39.26%	+9.11+	★★★
Ages 65 to 74 Years	23.50%	34.38%	+10.88+	★★
Ages 75 to 85 Years	23.60%	29.30%	+5.70	★★
Total	29.61%	38.78%	+9.17+	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	48.91%	62.77%	+13.86+	★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan of Michigan's performance ranked above the 90th percentile for the *Chlamydia Screening in Women—Ages 21 to 24 Years* measure indicator and ranked between the 75th and 89th percentile for *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Total* measure indicators, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-34] [**Quality**]

Strength #2: Meridian Health Plan of Michigan's performance ranked between the 75th and 89th percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicator, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-35] [**Quality** and **Access**]

Strength #3: Meridian Health Plan of Michigan's performance ranked between the 75th and 89th percentile for the *Blood Pressure Control for Patients With Diabetes* measure indicator, indicating members with diabetes had controlled blood pressure readings most of the time. The risk of cardiovascular disease rises as systolic blood pressure increases in patients with diabetes mellitus.[3-36] [**Quality** and **Access**]

Strength #4: Meridian Health Plan of Michigan demonstrated overall strength in its HEDIS data reporting, as **Meridian Health Plan of Michigan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan's performance for the *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, ranked between the 25th and 49th percentile and below the 25th percentile, respectively, indicating children who turned 15 months old during the measurement year were not having at least six well-child visits with a PCP during their first 15 months of life. Additionally, that children who turned 30 months old during the measurement year were not having at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence

[3-34] National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Mar 7, 2024.
[3-35] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.
[3-36] American Academy of Family Physicians. Effects of Intensive Blood Pressure Control in Patients with Diabetes Mellitus. Available at: https://www.aafp.org/pubs/afp/issues/2011/0301/p612a.html. Accessed on: Mar 7, 2024.

the health and development of a child, and they are a critical opportunity for screening and counseling.[3-37] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for the *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, ranked between the 25th and 49th percentile and below the 25th percentile, respectively. Some barriers noted by **Meridian Health Plan of Michigan** included incorrect member contact information for outreach and providers not referencing its Quick Reference Guide, which resulted in missed compliance opportunities for the measure.

Recommendation: While **Meridian Health Plan of Michigan** noted several interventions currently in place to target improvement, such as interactive text messaging services to provide health education on well-child visits, care gap reminders, collecting barrier assessment data, offering appointment scheduling assistance to members, and member gift card incentives for successful completion of well-child visits, performance remains low for the *Well-Child Visits in the First 30 Months of Life* measure. Therefore, HSAG recommends that **Meridian Health Plan of Michigan** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #2: Meridian Health Plan of Michigan's performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years* and *Ages 75 to 85 Years* measure indicators ranked between the 25th and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-38] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years* and *Ages 75 to 85 Years* measure indicators ranked between the 25th and 49th percentile. A barrier noted by **Meridian Health Plan of Michigan** was incorrect member contact information for outreach and missed appointments.

Recommendation: While **Meridian Health Plan of Michigan** noted several interventions currently in place to target improvement, such as more diverse member outreach methods, expanded vendor relationships to include in-home screening kits, and text message reminders to members due for kidney evaluation, performance remains low for the *Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years* and *Ages 75 to 85 Years* measure indicators. Therefore, HSAG recommends that **Meridian Health Plan of Michigan** continue its efforts to improve performance for the *Kidney Health Evaluation for Patients With Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

[3-37] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

[3-38] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Mar 7, 2024.

Compliance Review

Performance Results

Table 3-60 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-60 also presents **Meridian Health Plan of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Meridian Health Plan of Michigan** was subject to a corrective action review process outlined in Appendix A.

Table 3-60—Compliance Review Results for MER

Standard		Number of Scores			Compliance Scores	
		Met	*Satisfied*[1]	*Not Met*	MER[2]	Statewide[3]
1	Administrative	5	0	0	100%	100%
2	Providers	22	0	1	96%	94.7%
3	Members	28	0	1	97%	97.7%
4	Quality	22	0	0	100%	99.5%
5	MIS/Financial	37	0	3	93%	96.1%
6	OIG/Program Integrity	35	0	0	100%	90.2%
Overall		**149**	**0**	**5**	**97%**	**95.5%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

[2] MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

[3] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **Meridian Health Plan of Michigan** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan of Michigan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Meridian Health Plan of Michigan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs; QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Meridian Health Plan of Michigan achieved full compliance in the OIG/Program Integrity standard, demonstrating that the MHP had a sufficient compliance program, which included, but was not limited to, quarterly program integrity forms for tips and grievances; data mining; audits; provider disenrollments; overpayments; explanation of benefits reporting requirements; provider prepayment review; encounter adjustments; and annual program integrity report. [**Quality** and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: While **Meridian Health Plan of Michigan** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for the element *3.6-A Member Appeals*. [**Timeliness** and **Access**]

Why the weakness exists: Meridian Health Plan of Michigan had multiple standard and expedited appeals that were not resolved timely and with no explanation. The MHP reported that it had conducted a root cause analysis and remediation plan for each appeal case that was timely.

Recommendation: Meridian Health Plan of Michigan was required to submit a CAP to address element 3.6-A, which was approved by MDHHS. As such, HSAG recommends that **Meridian Health Plan of Michigan** continue to implement action plans and oversight and monitoring processes to ensure that all appeals are resolved timely.

Weakness #2: While **Meridian Health Plan of Michigan** demonstrated high performance overall (i.e., 90 percent or greater but less than 100 percent) in the MIS/Financial standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *5.3 Quarterly Financials*, *5.11 Claims Processing (Non-Pharmacy)*, and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. [**Quality** and **Timeliness**]

Why the weakness exists: Although **Meridian Health Plan of Michigan** completed the required quarterly financial statement, due to an administrative error, the submission was left out of the packet submitted to MDHHS, which resulted in the MHP receiving a *Not Met* score. Additionally, **Meridian Health Plan of Michigan** reported that noncompliance for the ending encounter inventory over 45 days that was greater than 1 percent for half of the months during the review period and the one month where the percentage of rejected/denied claims was greater than 12

percent was the result of a claims processing system migration to a new encounter processing system causing unforeseen issues and need for additional staff training. Also, **Meridian Health Plan of Michigan** reported that professional encounter acceptance rate noncompliance resulted from incorrect use of claims processing logic.

Recommendation: Meridian Health Plan of Michigan was required to submit a CAP to address elements 5.3, 5.11, and 5.15, which was approved by MDHHS. As such, HSAG recommends that **Meridian Health Plan of Michigan** continue to implement action plans and monitoring processes to ensure adherence to MDHHS' report submission requirements and encounter data processing requirements (i.e., *Quarterly Financial Statements and Reports that were submitted to DIFS* [Department of Insurance and Financial Services]; *Maintain less than 1% of ending inventory greater than 45 days*; *Percent of rejected claims must be 12% or less;* and *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS*).

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 321 cases by comparing provider data that **Meridian Health Plan of Michigan** submitted to HSAG against **Meridian Health Plan of Michigan**'s online provider directory. The sample included 156 PCPs, 138 pediatric providers, and 27 OB/GYN providers (Table 3-61). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 96.9 percent (n=311) of the reviews. The sampled providers were not found in the online provider directory in 3.1 percent (n=10) of the reviewed cases.

Table 3-61—Summary of Providers Present in the Directory by Provider Category

		Providers Found in Directory		Providers Not Found in Directory	
Provider Category	Number of Sampled Providers	Count	%	Count	%
PCPs	156	150	96.2%	6	3.8%
Pediatric Providers	138	137	99.3%	1	0.7%
OB/GYN Providers	27	24	88.9%	3	11.1%
MER Total	**321**	**311**	**96.9%**	**10**	**3.1%**

Table 3-62 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Meridian Health Plan of Michigan**'s provider data submission to HSAG and **Meridian Health Plan of Michigan**'s online provider directory.

Table 3-62—Provider Demographic Indicators Matching Online Provider Directory

	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%	Count	%
Provider's Name	150	100%	137	100%	24	100%	311	100%
Provider Street Address	144	96.0%	136	99.3%	22	91.7%	302	97.1%
Provider Suite Number	148	98.7%	137	100%	22	91.7%	307	98.7%
Provider City	144	96.0%	137	100%	23	95.8%	304	97.7%
Provider State	150	100%	137	100%	24	100%	311	100%
Provider ZIP Code	144	96.0%	137	100%	23	95.8%	304	97.7%
Provider Telephone Number	119	79.3%	112	81.8%	20	83.3%	251	80.7%
Provider Type/Specialty	140	93.3%	137	100%	24	100%	301	96.8%
Provider Accepting New Patients	149	99.3%	137	100%	24	100%	310	99.7%
Provider Gender	148	98.7%	136	99.3%	24	100%	308	99.0%
Provider Primary Language*	150	100%	20	14.6%	3	12.5%	173	55.6%
Non-English Language Speaking Provider (including American Sign Language)*	139	92.7%	127	92.7%	22	91.7%	288	92.6%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 244 sampled provider locations (i.e., "cases") for **Meridian Health Plan of Michigan**, with an overall response rate of 71.7 percent (n=175). Table 3-63 summarizes the secret shopper survey results for **Meridian Health Plan of Michigan**.

Table 3-63—Summary of MER Secret Shopper Survey Results

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
PCPs	112	64	57.1%	46	71.9%	45	70.3%	41	64.1%	30	46.9%
Pediatric Providers	112	95	84.8%	85	89.5%	82	86.3%	81	85.3%	64	67.4%

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
OB/GYN Providers	20	16	80.0%	14	87.5%	14	87.5%	14	87.5%	14	87.5%
MER Total	**244**	**175**	**71.7%**	**145**	**82.9%**	**141**	**80.6%**	**136**	**77.7%**	**108**	**61.7%**

Table 3-64 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Meridian Health Plan of Michigan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-64—Appointment Availability Results

			Cases Offered an Appointment			Appointment Wait Time (Days)				
Provider Category	Total Survey Cases	Cases Accepting New Patients	Count	Rate Among All Surveyed Cases[1] (%)	Rate Among Cases Accepting New Patients[2] (%)	Min	Max	Average	Median	Percentage of Cases Within Standard[3]
PCPs	112	24	11	9.8%	45.8%	0	113	34	24	54.5%
Pediatric Providers	112	56	42	37.5%	75.0%	1	98	19	10	76.2%
OB/GYN Providers	20	14	8	40.0%	57.1%	3	12	8	9	37.5%
MER Total	**244**	**94**	**61**	**25.0%**	**64.9%**	**0**	**113**	**20**	**10**	**67.2%**

[1] The denominator includes all surveyed cases included in the sample.
[2] The denominator includes cases responding to the survey that accept the insurance and new patients.
[3] The denominator includes cases offered an appointment. The MDHHS appointment timeliness standards are 30 business days for routine care appointments and seven business days for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Reviewers located over 96 percent of the sampled providers in **Meridian Health Plan of Michigan**'s online provider directory. Of the providers that reviewers located in the online directory, 11 of 12 indicators had a match rate above 90 percent. [**Access**]

Weaknesses and Recommendations

Weakness #1: Only 71.7 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **Meridian Health Plan of Michigan**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of the locations reached, only 77.7 percent confirmed the services were offered and 61.7 percent confirmed the requested insurance was accepted. [**Quality** and **Access**]

Why the weakness exists: **Meridian Health Plan of Michigan**'s provider data included invalid specialty and insurance information.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

Weakness #3: Of the cases responding to the survey and accepting the insurance and new patients, only 64.9 percent of locations offered an appointment date. However, OB/GYN providers had an appointment availability rate of 57.1 percent, while PCP locations had an appointment availability rate of 45.8 percent. [**Access**]

Why the weakness exists: For new **Meridian Health Plan of Michigan** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Meridian Health Plan of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **Meridian Health Plan of Michigan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Meridian Health Plan of Michigan**'s original questionnaire responses, and **Meridian Health Plan of Michigan** responded to these specific questions. To support its questionnaire responses, **Meridian Health Plan of Michigan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Meridian Health Plan of Michigan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-65 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-65—EDV Results for MER

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Meridian Health Plan of Michigan** utilized Edifecs (SpecBuilder and Xengine) and Encounter Data Manager as its primary software for claim adjudication and encounter preparation. • **Meridian Health Plan of Michigan** had processes in place to detect and identify duplicate claims. **Meridian Health Plan of Michigan** clarified that it did not submit rejected and voided claims. In cases requiring adjustments, the claim frequency code "7" was used to indicate an adjusted encounter. • **Meridian Health Plan of Michigan** delegated the responsibility of collecting and maintaining provider information for their respective services to its subcontractors. Regarding enrollment data, **Meridian Health Plan of Michigan** managed data received from MDHHS through 834 files, providing daily Medicaid enrollment updates to the MHPs for integration into their claim processing systems. **Meridian Health Plan of Michigan** ensured that subcontractors also

Analysis	Key Findings
	received and incorporated these enrollment details into their respective claim systems.
Payment Structures	• **Meridian Health Plan of Michigan** employed diverse claim payment methods for different encounter types. In inpatient encounters, it employed DRG and negotiated (flat) rate methods. For outpatient encounters, the methods included line-by-line, per diem, capitation, and negotiated (flat) rate. Pharmacy encounters were processed using the transparent pricing model method. • In general, **Meridian Health Plan of Michigan** processed claims with TPL based on the collected insurance coverage information. When a claim suggests the existence of additional primary insurance for a member, the MHP's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details.
Encounter Data Quality Monitoring	• **Meridian Health Plan of Michigan** indicated it did not store any of its subcontractor data. • **Meridian Health Plan of Michigan** and/or its subcontractors performed several data quality checks on the encounter data collected. These checks included, but were not limited to, analyzing claim volume by submission month (for dental), assessing field-level completeness and validity (for all subcontractor encounters except vision), and evaluating timeliness (for dental and NEMT). • For encounters collected by **Meridian Health Plan of Michigan**, it conducted claim volume by submission month, field-level completeness and validity, timeliness, and State measures pertaining to claims volume, timeliness, and acceptance rate.
Administrative Profile	
Encounter Data Completeness	• **Meridian Health Plan of Michigan** displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • **Meridian Health Plan of Michigan** had a low volume of duplicate encounters, with 0.2 percent of professional encounters, 0.1 percent of institutional encounters, 0.5 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative.

Analysis	Key Findings
Encounter Data Timeliness	• **Meridian Health Plan of Michigan** demonstrated timely submission of dental and pharmacy encounters. Within 90 days, **Meridian Health Plan of Michigan** submitted 99.9 percent of dental encounters, and within 60 days, **Meridian Health Plan of Michigan** submitted 99.1 percent of pharmacy encounters to MDHHS after the payment date. • Although **Meridian Health Plan of Michigan** demonstrated timely submission of professional and institutional encounters overall, it demonstrated a slower submission rate compared to dental and pharmacy encounters. Within 60 days, **Meridian Health Plan of Michigan** submitted 90.1 percent of professional encounters to MDHHS after the payment date, and within 210 days, it submitted 98.2 percent of encounters to MDHHS after the payment date. Within 270 days of the payment date, **Meridian Health Plan of Michigan** submitted 99.2 percent of professional encounters to MDHHS. • Within 60 days, **Meridian Health Plan of Michigan** submitted 90.9 percent of institutional encounters, and within 330 days, it submitted 98.5 percent of encounters to MDHHS after the payment date. • **Meridian Health Plan of Michigan**'s submitted data contained a missing paid or submission date for 0.1 percent of professional encounters, 1.4 percent of institutional encounters, and less than 0.1 percent of pharmacy encounters.
Field-Level Completeness and Accuracy	• In **Meridian Health Plan of Michigan**'s submitted institutional encounters, the Paid Date and the Detail Paid Amount fields were populated 93.4 percent of the time. • All other data elements in **Meridian Health Plan of Michigan**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Meridian Health Plan of Michigan**'s submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the enrollment data. • Of all identified member IDs in **Meridian Health Plan of Michigan**'s submitted pharmacy data, 99.9 percent were identified in the enrollment data. • Of all identified provider NPIs in **Meridian Health Plan of Michigan**'s submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the provider data. • Of all identified provider NPIs in **Meridian Health Plan of Michigan**'s submitted pharmacy encounter data, 96.4 percent were identified in the provider data.

Analysis	Key Findings
Encounter Data Logic	• No major concerns were noted for **Meridian Health Plan of Michigan**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan of Michigan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The MHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Meridian Health Plan of Michigan submitted dental and pharmacy encounters in a timely manner from the payment date, with about 98 percent of all encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all categories of service, key data elements for **Meridian Health Plan of Michigan** were populated at high rates and generally greater than 95 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan indicated that it did not store any of its subcontractor data. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Meridian Health Plan of Michigan**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support the **Meridian Health Plan of Michigan**'s overall capabilities, it should consider storing its subcontractor encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #2: Meridian Health Plan of Michigan did not indicate any quality checks performed for claims/encounters from its vision subcontractor. [**Quality**]

Why the weakness exists: Ensuring data accuracy, completeness, and timeliness requires the implementation of claims/encounter quality checks.

Recommendation: Meridian Health Plan of Michigan should develop a comprehensive suite of monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its subcontractor.

Weakness #3: Although **Meridian Health Plan of Michigan** submitted dental and pharmacy encounters in a timely manner, **Meridian Health Plan of Michigan** did not submit professional or institutional encounters timely. About 98 percent of professional encounters were submitted within 210 days of payment, and 98 percent of institutional encounters were submitted within 330 days from payment. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Meridian Health Plan of Michigan should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #4: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 94 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: Meridian Health Plan of Michigan should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Weakness #5: Although payment dates and detail payment amounts were submitted 100 percent of the time in professional data, **Meridian Health Plan of Michigan** submitted these fields 93.4 percent of the time in institutional data. [**Quality**]

Why the weakness exists: Payment dates and detail payment amounts are key data fields that allow for accurate results in rate setting analyses.

Recommendation: Meridian Health Plan of Michigan should continue to evaluate its data for accuracy and completeness for all key data elements, including these fields.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-66 presents **Meridian Health Plan of Michigan**'s 2022 and 2023 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-66—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for MER

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Global Ratings				
Rating of Health Plan	61.67%	63.76%	68.80%	70.29%
Rating of All Health Care	49.59%	56.58%	68.67%	68.64%
Rating of Personal Doctor	63.16%	65.22%	74.02%	73.58%
Rating of Specialist Seen Most Often	61.64%+	64.65%+	69.57%+	75.76%+
Composite Measures				
Getting Needed Care	79.21%+	81.81%	85.09%	87.24%
Getting Care Quickly	78.82%+	82.68%	88.70%+	89.03%
How Well Doctors Communicate	89.04%	91.44%	95.38%	95.61%
Customer Service	90.60%+	90.55%+	86.49%+	96.14%+ ↑
Individual Item Measure				
Coordination of Care	72.73%+	87.37%+ ▲	85.94%+	94.19%+ ↑
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	74.10%	78.13%	—	—
Discussing Cessation Medications	54.94%	55.20%	—	—
Discussing Cessation Strategies	45.96%	50.39%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan of Michigan's 2023 top-box score was statistically significantly higher than the 2022 adult Medicaid top-box score for one measure, *Coordination of Care*. [**Quality**]

Strength #2: Meridian Health Plan of Michigan's 2023 top-box scores were statistically significantly higher than the 2022 child Medicaid national averages for two measures, *Customer Service* and *Coordination of Care*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult and child Medicaid national averages or 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—CSHCS

Table 3-67 presents **Meridian Health Plan of Michigan**'s 2022 and 2023 CSHCS CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-67—Summary of CSHCS CAHPS Survey Top-Box Scores for MER

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	65.63%	63.98%
Rating of Health Care	71.65%	68.69% NA
Rating of Specialist Seen Most Often	73.59%	75.54%
Rating of CMDS Clinic	77.78%+	56.41%+ ▼ NA

	2022 Top-Box Score	2023 Top-Box Score
Composite Measures		
Customer Service	85.84%+	83.12%+ NA
How Well Doctors Communicate	95.17%	93.08% NA
Access to Specialized Services	70.54%+	64.39%+ NA
Transportation	74.26%+	54.66%+ NA
Individual Item Measures		
Access to Prescription Medicines	88.67%	86.92%
CMDS Clinics	77.14%+	80.95%+ NA
Local Health Department Services	78.57%	77.68% NA
Not Felt Treated Unfairly: Race and Ethnicity	99.22%	96.98% NA
Not Felt Treated Unfairly: Health Insurance Type	93.31%	92.78% NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan of Michigan's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no strengths were identified.

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan's 2023 top-box score was statistically significantly lower than the 2022 top-box score for one measure, *Rating of CMDS Clinic*. [**Quality**]

Why the weakness exists: When compared to 2022 top-box scores, the results indicate that parents/caretakers of child members enrolled in **Meridian Health Plan of Michigan** may not find services offered by CMDS clinics to be useful for their child.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** explore drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **Meridian Health Plan of Michigan** should consider obtaining direct patient feedback from members to drill down into areas that need improvement.

Performance Results—HMP

Table 3-68 presents **Meridian Health Plan of Michigan**'s 2022 and 2023 HMP CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-68—Summary of HMP CAHPS Top-Box Scores for MER

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	64.44%	54.22% ▼↓
Rating of All Health Care	53.40%	55.07%
Rating of Personal Doctor	70.42%	64.33%
Rating of Specialist Seen Most Often	58.46%+	62.92%+
Composite Measures		
Getting Needed Care	75.71%+	80.86%
Getting Care Quickly	79.01%+	78.49%
How Well Doctors Communicate	89.81%	91.53%
Customer Service	90.00%+	86.92%+
Individual Item Measure		
Coordination of Care	75.00%+	81.58%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	76.43%	72.93%
Discussing Cessation Medications	56.96%	52.24%
Discussing Cessation Strategies	45.86%	43.28%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.

Strengths, Weaknesses, and Recommendations—HMP

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Meridian Health Plan of Michigan's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Meridian Health Plan of Michigan's 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average and the 2022 top-box score for one measure, *Rating of Health Plan* [**Quality**].

Why the weakness exists: When compared to national benchmarks and the 2022 top-box scores, the results indicate that **Meridian Health Plan of Michigan**'s members are reporting more negative experiences with their health plan overall. **Meridian Health Plan of Michigan** members may have felt they received inadequate information, poor communication or service, or a lack of quality of care from their providers or the health plan staff, which led to an overall lower rating of the health plan.

Recommendation: HSAG recommends that **Meridian Health Plan of Michigan** explore the drivers of this lower experience score and develop initiatives designed to improve members' quality of care, including a focus on improving members' overall experiences with their health plan.

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide, which is inclusive of **Meridian Health Plan of Michigan**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **Meridian Health Plan of Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Meridian Health Plan of Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Meridian Health Plan of Michigan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-69 displays each applicable performance area and the overall performance impact related to the quality, timeliness, and accessibility of healthcare services provided to **Meridian Health Plan of Michigan**'s Medicaid members.

Table 3-69—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access—Meridian Health Plan of Michigan** continued its MDHHS-mandated PIP focused on disparities in timeliness of prenatal care for Black (non-Hispanic) women residing in Region 6. **Meridian Health Plan of Michigan** demonstrated programmatically significant improvement over the baseline performance through the initiation of an intervention strategy to refer pregnant members due for prenatal care visits to CHWs for intensive outreach and engagement. **Meridian Health Plan of Michigan** should continue this intervention, but also develop additional interventions, that are tailored specifically for the disparate population (i.e., Black pregnant women in Region 6) to have the best chance of success at removing the barriers and improving the prevalence of timely prenatal care specifically for this population. Additionally, as demonstrated through the compliance review activity, **Meridian Health Plan of Michigan** met MDHHS' expectations for addressing health disparities through population health management as demonstrated by a 100 percent compliance score for the Quality standard; and specifically, a *Met* score for element *4.10 Addressing Health Disparities – Population Health Mgmt (PHM))*, demonstrating that it had adequate policies and procedures for providing population health management services. **Meridian Health Plan of Michigan** should continue to conduct data analysis through its quality program to identify and subsequently implement interventions to reduce disparities in healthcare. However, **Meridian Health Plan of Michigan**'s PIP did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period, and while not statistically significant, the rate demonstrated an 8.8 percentage points decline from the baseline rate. Additionally, the performance rate for the comparison group (White women residing in Region 6) demonstrated a statistically significant decrease in performance as compared to the baseline rate. These results indicate that many women are not receiving prenatal care within the first trimester. Prenatal care during the first trimester can lower the risk of pregnancy complications. Further, although the

Performance Area	Overall Performance Impact
	MHP identified barriers and corresponding interventions, they appear to be generalized to **Meridian Health Plan of Michigan**'s entire pregnant member population and not specific to its target population (i.e., Black [non-Hispanic] women residing in Region 6), which may have contributed to the lack of improvement in performance indicator 1 (*Improve the PPC-Timeliness of Prenatal Care rate for the Black [non-Hispanic] population residing in Region 6 in order to reduce the disparity to the comparison subgroup*). **Meridian Health Plan of Michigan** should ensure its PIP, including barriers and interventions, has a strong focus on its defined target population. Also, **Meridian Health Plan of Michigan**'s rate for the *Timeliness of Prenatal Care* HEDIS measure as reported in Appendix B demonstrated a slight decline from the prior year and also ranked below the 25th Medicaid Quality Compass percentile. **Meridian Health Plan of Michigan** should closely monitor for continued negative trends or new barriers that may be preventing women from receiving timely prenatal care appointments and regularly assess implemented interventions to determine whether they are having the impact intended (i.e., positive outcomes.) Further, the results of the NAV activity indicated that some of **Meridian Health Plan of Michigan**'s members may be experiencing challenges contacting or scheduling appointments with OB/GYN providers due to invalid information within the provider directory, including provider telephone number and the provider accepting insurance information. Lastly, of providers responding to the survey and accepting the insurance and new patients, only 57.1 percent of OB/GYN providers offered an appointment and only 37.5 percent of the OB/GYN providers who offered an appointment met MDHHS' appointment timeliness standard of 30 business days. **Meridian Health Plan of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members to further ensure members are able to obtain timely prenatal care and to educate providers on appointment timeliness requirements.
Preventive Care	**Quality**, **Timeliness**, and **Access**— The results of the PMV activity demonstrated strong performance for the Women—Adult Care domain. Specifically, for the *Chlamydia Screening in Women* measure, two of the three rates ranked between the 75th and 89th Medicaid Quality Compass percentile, while the third rate ranked at or above the 90th Medicaid Quality Compass percentile. Additionally, the *Cervical Cancer Screening* and *Breast Cancer Screening* measure rates ranked between the 50th and 74th Medicaid Quality Compass percentile. Regular checkups and screenings can lead to early detection and treatment of cervical and breast cancers and reduce the occurrence of serious complications. Additionally, all three rates under the *Chlamydia Screening in Women* measure and the *Breast Cancer Screening* measure rate demonstrated statistically significant improvement from the prior year. According to the CDC, chlamydia can cause permanent damage to a woman's reproductive system and potentially fatal ectopic pregnancy. Because

Performance Area	Overall Performance Impact
	chlamydia usually has no symptoms, screening is necessary to identify and subsequently treat the infection. **Meridian Health Plan of Michigan**'s PMV results confirm that many of its female members are being appropriately screened. Further, all rates under the *Child and Adolescent Well-Care Visits* measure ranked between the 50th and 74th Medicaid Quality Compass percentile, with three of the rates demonstrating a statistically significant increase from the prior year rates. Well-child visits are necessary for physicians to screen for any medical problems, including psychosocial concerns, provide guidance to parents, and promote better health outcomes. As demonstrated through the compliance review, **Meridian Health Plan of Michigan** also met MDHHS' expectations for monitoring appointment wait times for preventive services. Specifically, **Meridian Health Plan of Michigan** received a *Met* score for element *2.10 Provider Wait Times* under the Providers standard, which included but was not limited to monitoring of the following metrics: *Routine Care is available within 30 Business Days of request*, *Routine Dental Care is within 21 Business Days of request*, and *Preventive Dental Services is within six weeks of request*. However, results from the EQR activities also indicated areas for improvement in the Preventive Care program area. Specifically, for the *Well-Child Visits in the First 30 Months of Life* measure, both rates had a statistically significant decline from the prior year. The *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rate ranked below the 25th Medicaid Quality Compass percentile and the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* rate ranked between the 25th and 49th Medicaid Quality Compass percentile. **Meridian Health Plan of Michigan** should continue to monitor performance of these measures and implement initiatives to ensure its child members are receiving recommended well-child visits. Additionally, the results of the NAV activity indicated that some of **Meridian Health Plan of Michigan**'s members may be experiencing challenges making appointments with PCPs or pediatric providers due to inaccurate information within **Meridian Health Plan of Michigan**'s provider directory and provider offices informing members that they do not accept **Meridian Health Plan of Michigan** Medicaid insurance. Further, of the provider offices responding to the survey and accepting the insurance and new patients, only 45.8 percent of PCPs and 75 percent of pediatric providers offered an appointment, with only 54.5 percent and 76.2 percent of PCPs and pediatric providers, respectively, offering a timely appointment in accordance with MDHHS' standard of 30 business days. **Meridian Health Plan of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements.

Performance Area	Overall Performance Impact
	Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult Medicaid, child Medicaid, and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged from 64.33 percent to 73.58 percent. **Meridian Health Plan of Michigan** should also consider these results when determining potential barriers for members accessing preventive care.
Care for Chronic Conditions	**Quality, Timeliness, and Access—**Overall, **Meridian Health Plan of Michigan** demonstrated mostly positive results through the PMV and compliance activities pertaining to care for chronic conditions. The rates for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *Blood Pressure Control for Patients With Diabetes* measures were between the 75th and 89th Medicaid Quality Compass percentile. Additionally, the rates for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%), Eye Exam for Patients With Diabetes*, and *Kidney Health Evaluation for Patients With Diabetes—Ages 18–64 Years* and *Total*, and *Controlling High Blood Pressure* measures ranked between the 50th and 74th Medicaid Quality Compass percentile. Also, seven of the rates within the Living With Illness domain demonstrated a statistically significant improvement from the prior year rates, with all nine rates within this domain improving from the prior year. These results indicate that more of **Meridian Health Plan of Michigan**'s members were receiving care to manage their chronic conditions. Appropriate management of chronic conditions can reduce symptoms and the chance of serious complications and improve quality of life. Further, as demonstrated by a *Met* score for element *3.10 CSHCS PCP Requirements* under the Members standard within the compliance review activity, **Meridian Health Plan of Michigan** met MDHHS' expectations for assignment of PCPs for children and youth with complex chronic conditions. However, the results of the NAV activity indicated that some of **Meridian Health Plan of Michigan**'s members may be experiencing challenges making appointments with PCPs due to inaccurate provider directory information and PCPs indicating that they do not accept **Meridian Health Plan of Michigan** Medicaid insurance or new patients. Further, of PCP offices responding to the survey who indicated that they accepted **Meridian Health Plan of Michigan** Medicaid insurance and new patients, only 45.8 percent were offered an appointment and of those offered an appointment, only 54.5 percent were offered an appointment within 30 business days to meet MDHHS' appointment timeliness standard. **Meridian Health Plan of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements. Additionally, as indicated through the PMV activity, two rates under the *Kidney Health Evaluation for Patients With Diabetes* measure ranked between

Performance Area	Overall Performance Impact
	the 25th and 49th Medicaid Quality Compass percentile. These results indicate that some members between the ages of 65 and 85 years were not receiving annual kidney health evaluations and recommended blood and urine screening tests. **Meridian Health Plan of Michigan** should implement initiatives to address these lower performing measure rates. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult Medicaid, child Medicaid, and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged between 64.33 percent and 73.58 percent. **Meridian Health Plan of Michigan** should also consider these results when determining potential barriers for members accessing care for chronic conditions.
Health Information Systems and Technology	**Quality**, **Timeliness**, and **Access—Meridian Health Plan of Michigan** demonstrated strengths of its health information systems and technology through the PMV, compliance, and EDV activities. The PMV findings confirmed that **Meridian Health Plan of Michigan** was fully compliant with how it collected, stored, analyzed, and reported HEDIS data. All rates were *Reportable*, indicating that **Meridian Health Plan of Michigan** followed the NCQA technical specifications for the calculation of HEDIS performance measures, and no rates were determined to be materially biased. Additionally, although **Meridian Health Plan of Michigan** scored below the statewide average for the MIS/Financial standard within the compliance review activity, the MHP received a score of 93 percent, indicating that it met MDHHS' expectations for most requirements pertaining to **Meridian Health Plan of Michigan**'s MIS. Further, through the EDV activity, **Meridian Health Plan of Michigan** demonstrated its capability to collect, process, and transmit encounter data to MDHHS; submit dental and pharmacy encounter data timely; and populate valid key data elements for all service categories. However, through the EDV activity, several opportunities for improvement were identified for **Meridian Health Plan of Michigan**. The MHP indicated that it did not store any subcontractor data, did not indicate quality checks were performed for claims/encounters from its vision subcontractor, and did not submit professional or institutional encounters timely. **Meridian Health Plan of Michigan** should consider storing its subcontractor encounter data within its claims systems to ensure accessibility to the data; develop comprehensive monitoring reports to assess the accuracy, completeness, and timeliness of encounter data received from its subcontractors; and monitor its encounter data submissions to MDHHS to ensure encounters are submitted after payment. Additionally, as less pharmacy provider NPIs were identified in provider data than medical and dental provider NPIs, **Meridian Health Plan of Michigan** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers. Further, although payment dates and detail payment amounts were submitted 100 percent of the time in

Performance Area	Overall Performance Impact
	professional data, **Meridian Health Plan of Michigan** only submitted these fields 93.4 percent of the time in institutional data. **Meridian Health Plan of Michigan** should continue to evaluate its data for accuracy and completeness for all key data elements. Lastly, as demonstrated through the compliance review, **Meridian Health Plan of Michigan** was not fully compliant with MDHHS' requirement for *5.3 Quarterly Financials—Quarterly Financial Statements and Reports that were submitted to DIFS for FY2022 Q2*, *5.11 Claims Processing*, and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS.* **Meridian Health Plan of Michigan** should continue to implement action plans and monitoring processes to ensure all financial reporting and claims/encounter processing performance standards are consistently met.

Molina Healthcare of Michigan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2023 evaluated the technical methods of **Molina Healthcare of Michigan**'s PIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG determined the overall methodological validity of the PIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-70 displays the overall validation rating, the baseline rate, Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-70—Overall Validation Rating for MOL

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities for Timeliness of Prenatal Care	*Met*	1. Timeliness of Prenatal Care—Black	66.2%	68.4% ⇔		No
		2. Timeliness of Prenatal Care—White	71.1%	71.0% ⇔		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MHP conducted accurate data analysis and interpretation of PIP results; overall confidence that the PIP produced significant evidence of improvement).

The goals for **Molina Healthcare of Michigan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance for the comparison subgroup (White women), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-71 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-71—Remeasurement 1 Barriers and Interventions for MOL

Barriers	Interventions
Using monthly claim reports to identify pregnant members delays outreach and providing the program information to members.	To increase the number of Black members identified at the earliest point in their pregnancies, the MHP utilizes a vendor, Lucina, which employs a pregnancy-specific algorithm daily to all submitted claims. The reports are available on demand and allow for timely outreach, ensuring members are connected with pregnancy care and resources earlier in the pregnancy.
Members delay the initiation of prenatal care.	Members are offered a $100 gift card incentive for completion of a prenatal visit within the first trimester of their pregnancy or within 42 days of health plan enrollment.
	Members of childbearing age are emailed information regarding the importance of prenatal care, services to support a healthy pregnancy, and who to contact for additional information.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality**, **Access**, and **Timeliness**]

Strength #2: Molina Healthcare of Michigan eliminated the existing disparity between the Black and the White population with the first remeasurement period. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan partially achieved the state-defined goals, and the existing disparity was eliminated with the first remeasurement period. However, the comparison population demonstrated a very slight decline in performance as compared to the baseline. [**Quality**, **Access,** and **Timeliness**]

Why the weakness exists: While it is unclear what led to the slight decline in performance for the comparison group, **Molina Healthcare of Michigan** has made progress in improving performance for the disparate population.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** continue efforts to maintain or improve its performance for the comparison population. The MHP should also determine if any new barriers exist that are decreasing performance for this population.

Performance Measure Validation

Performance Results

Molina Healthcare of Michigan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2022 Compliance Audit Report findings, **Molina Healthcare of Michigan** was fully compliant with all seven IS standards.

According to the auditor's review, **Molina Healthcare of Michigan** followed the NCQA HEDIS MY 2022 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-72 displays the MDHHS-selected performance measures, HEDIS MY 2021 and MY 2022 rates, MY 2021 and MY 2022 comparisons, and MY 2022 performance levels based on comparisons to national percentiles[3-39] for **Molina Healthcare of Michigan**. Additional performance measures and performance measure results for **Molina Healthcare of Michigan** can be referenced in Appendix B.

Table 3-72—HEDIS MY 2022 Performance Measure Results for MOL

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	55.95%	60.34%	+4.39^{+}	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.53%	62.30%	+1.77^{+}	★★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	59.60%	59.81%	+0.21	★★★
Ages 12 to 17 Years	52.34%	52.58%	+0.24	★★★
Ages 18 to 21 Years	31.90%	30.90%	**-1.00^{++}**	★★★
Total	52.26%	52.05%	-0.21	★★★

[3-39] HEDIS MY 2022 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2021 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	62.05%	62.27%	+0.22	★★★★
Ages 21 to 24 Years	65.63%	67.89%	+2.26+	★★★★
Total	63.67%	64.89%	+1.22+	★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	57.21%	59.37%	+2.16	★★★
Breast Cancer Screening				
Breast Cancer Screening	51.37%	53.48%	+2.11+	★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)**	39.90%	41.85%	+1.95	★★
HbA1c Control (<8.0%)	51.82%	50.61%	-1.21	★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	57.18%	53.53%	-3.65	★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	62.77%	67.64%	+4.87	★★★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	27.62%	28.90%	+1.28+	★★
Ages 65 to 74 Years	30.61%	31.82%	+1.21	★★
Ages 75 to 85 Years	31.92%	26.87%	-5.05	★
Total	27.91%	29.07%	+1.16+	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	55.96%	63.26%	+7.30+	★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan's performance ranked between the 75th and 89th percentile for all *Chlamydia Screening in Women* measure indicators, indicating women 16 to 24 years of age identified as sexually active had at least one test for chlamydia during the measurement year most of the time. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-40] [**Quality**]

Strength #2: Molina Healthcare of Michigan's performance ranked between the 75th and 89th percentile for the *Blood Pressure Control for Patients With Diabetes* measure indicator, indicating members with diabetes had controlled blood pressure readings most of the time. The risk of cardiovascular disease rises as systolic blood pressure increases in patients with diabetes mellitus.[3-41] [**Quality** and **Access**]

Strength #3: Molina Healthcare of Michigan demonstrated overall strength in its HEDIS data reporting, as **Molina Healthcare of Michigan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan's performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years*, *Ages 65 to 74 Years*, and *Total* measure indicators ranked between the 25th and 49th percentile. Additionally, performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* measure indicator ranked below the 25th percentile, indicating some members with diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-42] [**Quality** and **Access**]

Why the weakness exists: The rates for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years*, *Ages 65 to 74 Years*, and *Total* measure indicators ranked between the 25th and 49th percentile. Additionally, performance for the *Kidney Health Evaluation for Patients With*

[3-40] National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Mar 7, 2024.

[3-41] American Academy of Family Physicians. Effects of Intensive Blood Pressure Control in Patients with Diabetes Mellitus. Available at: https://www.aafp.org/pubs/afp/issues/2011/0301/p612a.html. Accessed on: Mar 7, 2024.

[3-42] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Mar 7, 2024.

Diabetes—Ages 75 to 85 Years measure indicator ranked below the 25th percentile. A barrier identified by **Molina Healthcare of Michigan** was providers were slow to adopt ordering the required labs needed to meet measure requirements.

Recommendation: While **Molina Healthcare of Michigan** noted several interventions currently in place to target improvement, such as on-site or virtual visits with providers to explain the tests needed for measure compliance and provider incentives, performance for the *Kidney Health Evaluation for Patients With Diabetes* remained low. Therefore, HSAG recommends that **Molina Healthcare of Michigan** continue its efforts to improve performance for the *Kidney Health Evaluation for Patients With Diabetes* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #2: Molina Healthcare of Michigan's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-43] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentile. A barrier noted by **Molina Healthcare of Michigan** was incorrect member contact information.

Recommendation: While **Molina Healthcare of Michigan** noted several interventions currently in place to target improvement, such as using various methods of outreach to members, providing member education, sending reminders within a month after the members' birth to serve as a reference for parents regarding scheduling of all well-child visits, and providing outreach materials in multiple languages, performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator remains low. Therefore, HSAG recommends that **Molina Healthcare of Michigan** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #3: Molina Healthcare of Michigan's performance for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicator ranked between the 25th and 49th percentile, indicating members with diabetes did not aways have controlled HbA1c levels. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-44] [**Quality** and **Access**]

[3-43] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

[3-44] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.

Why the weakness exists: The rate for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicator ranked between the 25th and 49th percentile, suggesting barriers exist for members with diabetes to have controlled HbA1c levels.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled HbA1c levels. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicator.

Compliance Review

Performance Results

Table 3-73 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-73 also presents **Molina Healthcare of Michigan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Molina Healthcare of Michigan** was subject to a corrective action review process outlined in Appendix A.

Table 3-73—Compliance Review Results for MOL

Standard		Number of Scores			Compliance Scores	
		Met	*Satisfied*[1]	*Not Met*	MER[2]	Statewide[3]
1	Administrative	5	0	0	100%	100%
2	Providers	22	0	1	96%	94.7%
3	Members	29	0	0	100%	97.7%
4	Quality	22	0	0	100%	99.5%
5	MIS/Financial	39	1	0	98%	96.1%
6	OIG/Program Integrity	34	0	1	97%	90.2%
Overall		**151**	**1**	**2**	**98%**	**95.5%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

[2] MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

[3] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the

results of the focus studies are not incorporated into the scoring of the compliance review, **Molina Healthcare of Michigan** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Molina Healthcare of Michigan achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Strength #3: Molina Healthcare of Michigan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs; QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for **Molina Healthcare of Michigan** through the compliance review activity.

Why the weakness exists: NA

Recommendation: NA

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 346 cases by comparing provider data that **Molina Healthcare of Michigan** submitted to HSAG against **Molina Healthcare of Michigan**'s online provider directory. The sample included 163 PCPs, 163 pediatric providers, and 20 OB/GYN providers (Table 3-74). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 94.2 percent (n=326) of the reviews. The sampled providers were not found in the online provider directory in 5.8 percent (n=20) of the reviewed cases.

Table 3-74—Summary of Providers Present in the Directory by Provider Category

		Providers Found in Directory		Providers Not Found in Directory	
Provider Category	Number of Sampled Providers	Count	%	Count	%
PCPs	163	158	96.9%	5	3.1%
Pediatric Providers	163	149	91.4%	14	8.6%
OB/GYN Providers	20	19	95.0%	1	5.0%
MOL Total	**346**	**326**	**94.2%**	**20**	**5.8%**

Table 3-75 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Molina Healthcare of Michigan**'s provider data submission to HSAG and **Molina Healthcare of Michigan**'s online provider directory.

Table 3-75—Provider Demographic Indicators Matching Online Provider Directory

	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%	Count	%
Provider's Name	158	100%	149	100%	19	100%	326	100%
Provider Street Address	155	98.1%	143	96.0%	18	94.7%	316	96.9%
Provider Suite Number	156	98.7%	145	97.3%	18	94.7%	319	97.9%
Provider City	158	100%	149	100%	19	100%	326	100%
Provider State	158	100%	149	100%	19	100%	326	100%
Provider ZIP Code	157	99.4%	148	99.3%	19	100%	324	99.4%
Provider Telephone Number	152	96.2%	139	93.3%	19	100%	310	95.1%

	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%	Count	%
Provider Type/Specialty	158	100%	147	98.7%	18	94.7%	323	99.1%
Provider Accepting New Patients	149	94.3%	137	91.9%	17	89.5%	303	92.9%
Provider Gender	158	100%	149	100%	6	31.6%	313	96.0%
Provider Primary Language*	158	100%	148	99.3%	19	100%	325	99.7%
Non-English Language Speaking Provider (including American Sign Language)*	116	73.4%	117	78.5%	18	94.7%	251	77.0%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 286 sampled provider locations (i.e., "cases") for **Molina Healthcare of Michigan**, with an overall response rate of 79.4 percent (n=227). Table 3-76 summarizes the secret shopper survey results for **Molina Healthcare of Michigan**.

Table 3-76—Summary of MOL Secret Shopper Survey Results

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
PCPs	143	112	78.3%	86	76.8%	83	74.1%	81	72.3%	67	59.8%
Pediatric Providers	127	99	78.0%	72	72.7%	70	70.7%	47	47.5%	42	42.4%
OB/GYN Providers	16	16	100%	9	56.3%	9	56.3%	7	43.8%	7	43.8%
MOL Total	**286**	**227**	**79.4%**	**167**	**73.6%**	**162**	**71.4%**	**135**	**59.5%**	**116**	**51.1%**

Table 3-77 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Molina Healthcare of Michigan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-77—Appointment Availability Results

			Cases Offered an Appointment			Appointment Wait Time (Days)				
Provider Category	Total Survey Cases	Cases Accepting New Patients	Count	Rate Among All Surveyed Cases[1] (%)	Rate Among Cases Accepting New Patients[2] (%)	Min	Max	Average	Median	Percentage of Cases Within Standard[3]
PCPs	143	65	41	28.7%	63.1%	1	129	24	14	75.6%
Pediatric Providers	127	39	29	22.8%	74.4%	0	142	24	15	75.9%
OB/GYN Providers	16	6	0	0.0%	0.0%	NA	NA	NA	NA	NA
MOL Total	**286**	**110**	**70**	**24.5%**	**63.6%**	**0**	**142**	**24**	**15**	**75.7%**

[1] The denominator includes all surveyed cases included in the sample.
[2] The denominator includes cases responding to the survey that accept the insurance and new patients.
[3] The denominator includes cases offered an appointment. The MDHHS appointment timeliness standards are 30 business days for routine care appointments and seven business days for prenatal care appointments.
NA Indicates that appointment wait time and compliance standards were not evaluated due to no cases offering an appointment.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the 94.2 percent of providers that reviewers located in **Molina Healthcare of Michigan**'s online provider directory, 11 of 12 indicators had match rates above 90 percent. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Of the 79.4 percent of locations reached, only 73.6 percent confirmed affiliation with the sampled provider. Additionally, 71.4 percent confirmed accuracy of the sampled address, 59.5

percent confirmed the services were offered, and 51.1 percent confirmed the requested insurance was accepted. [**Quality** and **Access**]

Why the weakness exists: **Molina Healthcare of Michigan**'s provider data included invalid provider, specialty, and insurance information.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

Weakness #2: Of the cases responding to the survey and accepting the insurance and new patients, only 63.6 percent of locations offered an appointment date. However, pediatric providers had an appointment availability rate of 74.4 percent, PCP locations had an appointment availability rate of 63.1 percent, while OB/GYN provider locations had an appointment availability rate of 0.0 percent. [**Access**]

Why the weakness exists: For new **Molina Healthcare of Michigan** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Molina Healthcare of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **Molina Healthcare of Michigan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Molina Healthcare of Michigan**'s original questionnaire responses, and **Molina Healthcare of Michigan** responded to these specific questions. To support its questionnaire responses, **Molina Healthcare of Michigan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Molina Healthcare of Michigan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-78 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-78—EDV Results for MOL

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Molina Healthcare of Michigan** utilized Molina Claims Gateway, QNXT, SQL and BizTalk, and MOVEit DMZ as its primary software for claim adjudication and encounter preparation. • **Molina Healthcare of Michigan** had processes in place to detect and identify duplicate claims. **Molina Healthcare of Michigan** clarified that it did not submit denied claims unless they were administrative denials and voided claims were also excluded from submission. In cases requiring adjustments, the claim frequency code "7" was used to indicate an adjusted encounter. • **Molina Healthcare of Michigan**, along with its subcontractors, holds the responsibility for collecting and maintaining provider information. In terms of enrollment data, SKYGEN, the dental services subcontractor, managed member data for dental services, while Access2Care, the NEMT subcontractor, managed member data for NEMT. **Molina Healthcare of Michigan** managed enrollment data received from MDHHS through 834 files, providing daily Medicaid

Analysis	Key Findings
	enrollment updates to the MHPs for integration into their claim processing systems. **Molina Healthcare of Michigan** ensured that subcontractors also received and incorporated these enrollment details into their respective claim systems.
Payment Structures	• **Molina Healthcare of Michigan** utilized a variety of claim payment methods tailored to different encounter types. For inpatient encounters, it employed per diem, DRG, and negotiated (flat) rate methods. Outpatient encounters were processed using line-by-line and negotiated (flat) rate methods, while pharmacy encounters followed the ingredient cost method. • In general, **Molina Healthcare of Michigan** processed claims with TPL based on the collected insurance coverage information. When a claim suggests the existence of additional primary insurance for a member, the MHP's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details.
Encounter Data Quality Monitoring	• **Molina Healthcare of Michigan** indicated it did not store any of its pharmacy subcontractor data. • **Molina Healthcare of Michigan** indicated it edited or made modifications to some of the subcontractor data (i.e., dental, NEMT, and vision). • **Molina Healthcare of Michigan** and/or its subcontractors performed several data quality checks on the encounter data collected by the subcontractors. These checks included, but were not limited, to analyzing claim volume by submission month (for all subcontractor encounters except pharmacy), assessing field-level completeness and validity (for all subcontractor encounters), evaluating timeliness (for all subcontractor encounters except pharmacy), and ensuring alignment between payment fields in claims and financial reports (for all subcontractor encounters). • For encounters collected by **Molina Healthcare of Michigan**, it conducted claim volume by submission month, field-level completeness and validity, and timeliness checks, and verified the alignment of payment fields in claims with the financial reports.

Analysis	Key Findings
Administrative Profile	
Encounter Data Completeness	• **Molina Healthcare of Michigan** displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • **Molina Healthcare of Michigan** had a low volume of duplicate encounters, with less than 0.1 percent of professional encounters, less than 0.1 percent of institutional encounters, 0.6 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative.
Encounter Data Timeliness	• **Molina Healthcare of Michigan** demonstrated timely submission of institutional and pharmacy encounters. Within 60 days, **Molina Healthcare of Michigan** submitted 93.9 percent of institutional encounters to MDHHS after the payment date, and within 180 days, it submitted 99.5 percent of institutional encounters. • Within 30 days, **Molina Healthcare of Michigan** submitted 95.0 percent of pharmacy encounters to MDHHS after the payment date. Within 360 days, **Molina Healthcare of Michigan** remained consistent with 95.3 percent of pharmacy encounters submitted to MDHHS after the payment date. However, **Molina Healthcare of Michigan**'s submitted pharmacy encounters had the submit date prior to the payment date for 1.9 percent of encounters, and 2.8 percent of encounters were missing either a paid or submission date. • Although **Molina Healthcare of Michigan** demonstrated timely submission of professional encounters overall, it demonstrated a slower submission rate compared to institutional and pharmacy encounters. Within 90 days, **Molina Healthcare of Michigan** submitted 90.8 percent of professional encounters to MDHHS after the payment date, and within 180 days, it submitted 91.9 percent of professional encounters to MDHHS after the payment date. Within 300 days, **Molina Healthcare of Michigan** submitted 95.6 percent of professional encounters to MDHHS after the payment date. • **Molina Healthcare of Michigan** did not demonstrate timely submission of dental encounters, with 6.7 percent of dental encounters submitted to MDHHS within 90 days of the payment date. Within 180 days, **Molina Healthcare of Michigan** submitted 9.4 percent of encounters, and within 360 days, **Molina Healthcare of Michigan** submitted 64.3 percent of dental encounters to MDHHS.
Field-Level Completeness and Accuracy	• All data elements in **Molina Healthcare of Michigan**'s submitted data had high rates of population and validity.

Analysis	Key Findings
Encounter Referential Integrity	• Of all identified member IDs in **Molina Healthcare of Michigan**'s submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the enrollment data. • Of all identified member IDs in **Molina Healthcare of Michigan**'s submitted pharmacy data, 99.9 percent were identified in the enrollment data. • Of all identified provider NPIs in **Molina Healthcare of Michigan**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. • Of all identified provider NPIs in **Molina Healthcare of Michigan**'s submitted pharmacy encounter data, 90.0 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Molina Healthcare of Michigan**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The MHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Molina Healthcare of Michigan submitted institutional and pharmacy encounters in a timely manner from the payment date, with about 95 percent of all encounters submitted within 90 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all categories of service, key data elements for **Molina Healthcare of Michigan** were populated at high rates and generally greater than 95 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan modified encounters from its subcontractors before submitting them to MDHHS. [**Quality**]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: Molina Healthcare of Michigan should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: Molina Healthcare of Michigan indicated that it did not store its pharmacy subcontractor data. [**Quality**]

Why the weakness exists: Storing subcontractor encounter data within **Molina Healthcare of Michigan**'s claims systems is essential for maintaining data quality, ensuring accurate claims processing, facilitating data analysis, and supporting overall healthcare management and accountability.

Recommendation: To support the **Molina Healthcare of Michigan**'s overall capabilities, it should consider storing its subcontractor encounter data within its claims systems, ensuring accessibility for various purposes.

Weakness #3: Although **Molina Healthcare of Michigan** submitted institutional and pharmacy encounters in a timely manner, **Molina Healthcare of Michigan** did not submit professional or dental encounters timely. About 95 percent of professional encounters were submitted within 300 days from payment, and 64 percent of institutional encounters were submitted within 360 days from payment. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: Molina Healthcare of Michigan should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #4: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 90 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: Molina Healthcare of Michigan should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-79 presents **Molina Healthcare of Michigan**'s 2022 and 2023 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-79—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for MOL

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Global Ratings				
Rating of Health Plan	61.98%	65.67%	63.27%	71.05%
Rating of All Health Care	55.75%	62.50%	65.87%	65.07%
Rating of Personal Doctor	64.71%	65.67%	68.50%	74.65%
Rating of Specialist Seen Most Often	67.00%	68.00%	57.45%+	70.91%+
Composite Measures				
Getting Needed Care	87.01%	82.10%	83.72%+	85.43%
Getting Care Quickly	83.84%	79.94%	87.26%+	89.65%
How Well Doctors Communicate	88.63%	90.47%	94.62%	95.04%
Customer Service	94.88%+	83.68% ▼	93.31%+	91.67%+
Individual Item Measure				
Coordination of Care	83.84%+	87.18%	81.54%+	80.60%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	79.05%	82.45% ↑	—	—
Discussing Cessation Medications	61.84%	62.11% ↑	—	—
Discussing Cessation Strategies	54.81%	55.38% ↑	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for three measures: *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan's 2023 top-box score was statistically significantly lower than the 2022 adult Medicaid top-box score for one measure, *Customer Service.* [**Quality**]

Why the weakness exists: When compared to national benchmarks, members enrolled in **Molina Healthcare of Michigan** may not be receiving the information or help needed or may be dissatisfied with the level of courtesy and respect offered by customer service. However, HSAG is unable to identify the MHP-specific barriers or other factors impacting drivers for these measures based on the information provided through this EQR.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** conduct an evaluation of current MHP call center hours and practices to determine if the hours and resources meet members' needs. **Molina Healthcare of Michigan** could further promote the use of existing after-hours customer service to improve customer service results. Furthermore, **Molina Healthcare of Michigan** could appoint workgroups from call center staff members to discuss and refine existing service standards to enhance staff interactions with members.

Performance Results—CSHCS

Table 3-80 presents **Molina Healthcare of Michigan**'s 2022 and 2023 CSHCS CAHPS top-box scores. The following measure could not be displayed in the table because this measure had fewer than 11 responses and was suppressed: *CSHCS Family Services*. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-80—Summary of CSHCS CAHPS Survey Top-Box Scores for MOL

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	64.18%	66.67%
Rating of Health Care	69.17%	66.43% NA
Rating of Specialist Seen Most Often	68.82%	75.13%
Rating of CMDS Clinic	80.95%+	84.38%+ NA
Composite Measures		
Customer Service	86.10%+	86.68%+ NA
How Well Doctors Communicate	93.41%	94.99% NA
Access to Specialized Services	73.36%+	67.36%+ NA
Transportation	82.35%+	64.84%+ NA
Individual Item Measures		
Access to Prescription Medicines	92.04%	89.62%
CMDS Clinics	87.18%+	80.56%+ NA
Local Health Department Services	76.60%+	74.24%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	95.79%	96.65% NA
Not Felt Treated Unfairly: Health Insurance Type	95.79%	90.87% ▼ NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity

have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan's 2023 top-box score was statistically significantly lower than the 2022 top-box score for one measure, *Not Felt Treated Unfairly: Health Insurance Type*. [**Quality**]

Why the weakness exists: While above 90 percent, when compared to the 2022 top-box scores, the results indicate that more **Molina Healthcare of Michigan** members felt they were treated unfairly by their healthcare provider due to their insurance type.

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** explore the drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **Molina Healthcare of Michigan** should consider obtaining direct patient feedback from members to drill down into areas that need improvement.

Performance Results—HMP

Table 3-81 presents **Molina Healthcare of Michigan**'s 2022 and 2023 HMP CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-81—Summary of HMP CAHPS Top-Box Scores for MOL

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	67.02%	65.05%
Rating of All Health Care	58.33%	65.31%$^{+}$
Rating of Personal Doctor	71.23%	67.38%
Rating of Specialist Seen Most Often	68.75%$^{+}$	68.06%$^{+}$
Composite Measures		
Getting Needed Care	76.90%$^{+}$	86.59%$^{+}$ ▲
Getting Care Quickly	80.51%$^{+}$	84.09%$^{+}$

	2022 Top-Box Score	2023 Top-Box Score
How Well Doctors Communicate	91.18%	95.50%
Customer Service	81.73%+	88.00%+
Individual Item Measure		
Coordination of Care	82.76%+	87.88%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	82.12%	87.20% ↑
Discussing Cessation Medications	58.78%	60.00% ↑
Discussing Cessation Strategies	48.32%	53.97%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.

Strengths, Weaknesses, and Recommendations—HMP

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina Healthcare of Michigan's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for two measures: *Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*. [**Quality**]

Strength #2: Molina Healthcare of Michigan's 2023 top-box score was statistically significantly higher than the 2022 top-box score for one measure, *Getting Needed Care*. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Molina Healthcare of Michigan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.
Why the weakness exists: NA

Recommendation: HSAG recommends that **Molina Healthcare of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide, which is inclusive of **Molina Healthcare of Michigan**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **Molina Healthcare of Michigan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Molina Healthcare of Michigan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Molina Healthcare of Michigan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-82 displays each applicable performance area and the overall performance impact related to the quality, timeliness, and accessibility of healthcare services provided to **Molina Healthcare of Michigan**'s Medicaid members.

Table 3-82—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access**—**Molina Healthcare of Michigan** continued its MDHHS-mandated PIP focused on disparities in timeliness of prenatal care. **Molina Healthcare of Michigan** identified a disparity between Black women and White women that was eliminated during the first remeasurement period. While **Molina Healthcare of Michigan** made progress in improving the rate of Black women receiving timely prenatal care, it did not achieve statistically significant improvement over the baseline for the first remeasurement period. These results align with the results of the HEDIS audit documented within the 2023 HEDIS Aggregate Report for Michigan Medicaid located in Appendix B. While **Molina Healthcare of Michigan**'s rate for the *Timeliness of Prenatal Care* measure demonstrated some improvement from the prior year, it ranked below the 25th Medicaid Quality Compass percentile. These results indicate that many women are not receiving prenatal care within the first trimester. Prenatal care during the first trimester can lower the risk of pregnancy complications. Additionally, through its PIP, while **Molina Healthcare of Michigan** identified barriers and corresponding interventions, they appear to be generalized to the MHP's entire pregnant member population and not specific to its target population (i.e., Black pregnant members). **Molina Healthcare of Michigan** should ensure its PIP, including barriers and interventions, has a strong focus on its defined target population (i.e., identify barriers specifically for Black pregnant women and implement interventions that are tailored to Black pregnant women).

Performance Area	Overall Performance Impact
	Further, **Molina Healthcare of Michigan** met MDHHS' expectations for addressing health disparities through population health management as demonstrated by a 100 percent compliance score for the Quality standard and specifically a *Met* score for element *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*. **Molina Healthcare of Michigan** demonstrated that it had adequate policies and procedures for providing population health management services. **Molina Healthcare of Michigan** should continue to conduct data analysis through its quality program to identify and subsequently implement interventions to reduce disparities in healthcare. Further, the results of the NAV activity indicate that some of **Molina Healthcare of Michigan**'s members may be experiencing challenges contacting or scheduling appointments with OB/GYN providers due to invalid information within the provider directory, including provider address, provider type/specialty, provider accepting new patients, and/or provider accepting insurance information. Lastly, of the OB/GYN offices responding to the survey and accepting the insurance and new patients, none of the OB/GYN providers offered an appointment. **Molina Healthcare of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members to further ensure members are able to obtain timely prenatal care.
Preventive Care	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity demonstrated strong performance for the *Chlamydia Screening in Women, Cervical Cancer Screening,* and *Breast Cancer Screening* measures, as the five rates for these measures ranked between the 50th and 74th or the 75th and 89th Medicaid Quality Compass percentiles. Regular checkups and screenings can lead to early detection and treatment of cervical and breast cancers and reduce the occurrence of serious complications. Additionally, while all three measure rates demonstrated improvement, two of the three rates for the *Chlamydia Screening in Women* measure demonstrated a statistically significant improvement from the prior year. According to the CDC, chlamydia can cause permanent damage to a woman's reproductive system and potentially fatal ectopic pregnancy. Because chlamydia usually has no symptoms, screening is necessary to identify and subsequently treat the infection. **Molina Healthcare of Michigan**'s PMV results confirm that many of its female members are being appropriately screened. Further, all measures for *Child and Adolescent Well-Care Visits* ranked between the 50th and 74th percentile, although one of the measure rates for *Ages 18–21 Years* demonstrated a statistically significant decline from the prior year rate. Well-child visits are necessary for physicians to screen for any medical problems, including psychosocial concerns, provide guidance to parents, and promote better health outcomes. **Molina Healthcare of Michigan** should continue to monitor these rates for further decline and determine if additional action is required.

Performance Area	Overall Performance Impact
	Additionally, as demonstrated through the compliance review activity, **Molina Healthcare of Michigan** met MDHHS' expectations for monitoring appointment wait times for which preventive services are rendered. Specifically, **Molina Healthcare of Michigan** received a *Met* score for element *2.10 Provider Wait Times* under the Providers standard, which included but was not limited to monitoring of the following metrics: *Routine Care is available within 30 Business Days of request*, *Routine Dental Care is within 21 Business Days of request*, and *Preventive Dental Services is within six weeks of request*. However, as demonstrated through the PMV activity, **Molina Healthcare of Michigan** has opportunities to increase the number of members receiving preventive services for well-care visits and certain screenings. The *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure rate ranked between the 25th and 49th Medicaid Quality Compass percentile. Although continued opportunities exist to improve access to well-care visits, it should be noted that both rates for the *Well-Child Visits in the First 30 Months of Life* demonstrated a statistically significant improvement from the prior year. Preventive care and screenings can monitor growth and development and reduce the chance of obtaining a vaccine preventable condition. Therefore, **Molina Healthcare of Michigan** should continue its efforts to improve performance for these measures as they appear to have been successful. Additionally, the results of the NAV activity indicate that some of **Molina Healthcare of Michigan**'s members may be experiencing challenges making appointments with PCPs or pediatric providers due to inaccurate information within **Molina Healthcare of Michigan**'s provider directory and provider offices informing members that they do not accept **Molina Healthcare of Michigan** Medicaid insurance. Further, of providers responding to the survey and accepting the insurance and new patients, 63.1 percent of PCPs and 74.4 percent of pediatric providers offered the caller an appointment, and 75.6 percent and 75.9 percent of PCPs and pediatric providers, respectively, offered a timely appointment that met MDHHS' appointment timeliness standard of 30 business days. **Molina Healthcare of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from its prior year or to the national average, the rates ranged from 65.67 to 74.65 percent. **Molina Healthcare of Michigan** should also consider these results when determining potential barriers for members accessing preventive care due to dissatisfaction with their PCP.

Performance Area	Overall Performance Impact
Care for Chronic Conditions	**Quality**, **Timeliness**, and **Access—Molina Healthcare of Michigan** demonstrated some positive results through the PMV and compliance activities as it pertains to chronic conditions. The *Blood Pressure Control for Patients With Diabetes* measure rate ranked between the 75th and 89th Medicaid Quality Compass percentile, and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)*, *Eye Exam for Patients with Diabetes*, and *Controlling High Blood Pressure* measure rates having all ranked between the 50th and 74th Medicaid Quality Compass percentile. The *Controlling High Blood Pressure* measure rate also demonstrated an increase of 7.30 percentage points from the prior year that was also a statistically significant increase. These results indicate that some of **Molina Healthcare of Michigan**'s members were receiving care to manage their chronic conditions. Appropriate management of chronic conditions can reduce symptoms and the chance of serious complications and improve quality of life. Further, as demonstrated by a *Met* score for element *3.10 CSHCS PCP Requirements* under the Members standard of the compliance review, **Molina Healthcare of Michigan** met MDHHS' expectations for assignment of PCPs for children and youth with complex chronic conditions. However, the results of the NAV activity indicated that some of **Molina Healthcare of Michigan**'s members may be experiencing challenges making appointments with PCPs due to inaccurate provider directory information, and PCPs indicating they do not accept **Molina Healthcare of Michigan** Medicaid insurance or new patients. Additionally, only 63.1 percent of PCPs accepting new patients offered an appointment, with only 75.6 percent of those PCPs who offering an appointment within 30 business days to comply with the MDHHS appointment timeliness standard. **Molina Healthcare of Michigan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members, and educate providers on appointment timeliness requirements. Further, through the PMV activity, opportunities for improvement exist for **Molina Healthcare of Michigan** members who have diabetes as the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (>9.0%),* and three of the four measure rates for *Kidney Health Evaluation for Patients With Diabetes* ranked between the 25th and 49th Medicaid Quality Compass percentile, while the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 years* measure rate ranked below the 25th percentile. **Molina Healthcare of Michigan** should continue its initiatives to address identified barriers and those initiatives should be monitored and expanded upon as additional contributing factors are identified. Lastly, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid, and HMP populations did not demonstrate a statistically significant higher or lower score from its prior year or to the national average, the rates ranged from 65.67 and 74.65 percent. **Molina Healthcare of**

Performance Area	Overall Performance Impact
	Michigan should also consider these results when determining potential barriers for members accessing care for chronic conditions.
Health Information Systems and Technology	**Quality**, **Timeliness**, and **Access—Molina Healthcare of Michigan** demonstrated strengths of its health information systems and technology through the PMV, compliance, and some of the EDV activities. The PMV findings confirmed that **Molina Healthcare of Michigan** was fully compliant with how it collected, stored, analyzed, and reported HEDIS data. All rates were *Reportable*, indicating that **Molina Healthcare of Michigan** followed the NCQA technical specifications for the calculation of HEDIS performance measures, and no rates were determined to be materially biased. Additionally, **Molina Healthcare of Michigan** scored above the statewide average for the MIS/Financial standard of the compliance review, as it received a score of 98 percent, indicating that it met MDHHS' expectations for nearly all requirements pertaining to **Molina Healthcare of Michigan**'s MIS. Further, through the EDV activity, **Molina Healthcare of Michigan** demonstrated its capability to collect, process, and transmit encounter data to MDHHS; submit institutional and pharmacy encounter data timely; and populated valid key data elements for all service categories. However, the EDV results identified that the MHP made modifications to the subcontractor's encounters before submitting them to MDHHS.As such, to maintain data integrity, **Molina Healthcare of Michigan** should collaborate with MDHHS to confirm that modifications to subcontractors' encounters do not require that the adjustments be sent back to the subcontractors. Additionally, a**s Molina Healthcare of Michigan** indicated that it did not store its pharmacy subcontractor data, **Molina Healthcare of Michigan** should consider storing subcontractor encounter data within its claims systems, ensuring accessibility to data for varied purposes. **Molina Healthcare of Michigan** also did not submit professional or dental encounters timely which could lead to incomplete analyses and inaccurate results; therefore, **Molina Healthcare of Michigan** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment. Further, as less pharmacy provider NPIs were identified in provider data than medical and dental provider NPIs, **Molina Healthcare of Michigan** should also collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers. Lastly, as demonstrated through the compliance review, **Molina Healthcare of Michigan** was not fully compliant with meeting the *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS* metrics under compliance review element *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. Therefore, **Molina Healthcare of Michigan** should continue to implement action plans and monitoring processes to ensure all claims processing performance standards are consistently met.

Priority Health Choice

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2023 evaluated the technical methods of **Priority Health Choice**'s PIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG determined the overall methodological validity of the PIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-83 displays the overall validation rating, the baseline rate, Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-83—Overall Validation Rating for PRI

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Improving Timeliness of Prenatal Care for African-American Women	*Met*	1. The percentage of African-American women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health.	69.4%	65.8% ⇔		Yes
		2. The percentage of Caucasian women that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Priority Health.	86.1%	85.4% ⇔		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MHP conducted accurate data analysis and interpretation of PIP results; overall confidence that the PIP produced significant evidence of improvement).

The goals for **Priority Health Choice**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (African-American women) will demonstrate a statistically significant increase over the baseline rate without a decline in performance

for the comparison subgroup (Caucasian women), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-84 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-84—Remeasurement 1 Barriers and Interventions for PRI

Barriers	Interventions
Low prenatal engagement for African-American women due to the lack of understanding of prenatal care.	PriorityMOM: Program engages pregnant women via email to provide resources for a healthy pregnancy and postpartum period. Topics include cost/coverage, hypertension, diabetes, mental health, finding an OB, healthy nutrition, pre-term birth prevention, and postpartum care. Members receive a blood pressure cuff and baby sleep sack as a gift. Members also provide feedback on their experience.
	Strong Beginnings: Program focuses on improving health outcomes for minority pregnant members. Provider is incentivized if pregnant women complete their first trimester visit. The program focuses on provider engagement, addresses SDOH and racial equity. Family engagement is also a focus area along with mental health services.
Members have mental health challenges that impact their ability to receive prenatal care.	PriorityMOM: Program engages pregnant women to provide resources for a healthy pregnancy and postpartum period. Mental health topics included mental health diagnosis, mental health awareness, postpartum depression, and mental health support.
Members have mental health challenges that impact their ability to receive prenatal care.	Michigan Clinical Consultation and Care (MC3) Partnership: The MHP partnered with MC3 to help support women with their mental health needs. MC3 offers no-cost psychiatry support to pediatric and prenatal care providers in Michigan. Providers can connect with MC3 via phone to receive guidance on diagnostic questions, safe medications, and appropriate psychotherapy.
Low engagement in the MIHP.	The MHP encourages members to enroll in an MIHP program to help address social as well as racial needs. Members who enroll in an MIHP program and complete their postpartum visit receive free diapers. The MHP also meets with MIHPs to share resources and information that benefits members and the MIHPs.
Initial prenatal care visit is conducted with a nurse or other office staff instead of with an OB/GYN or other prenatal/primary care practitioner.	Provided training to providers on prenatal care visit requirements via the provider newsletter. Review 2022 hybrid findings to identify if this is an ongoing barrier.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Priority Health Choice initiated interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Priority Health Choice demonstrated clinically significant improvement over the baseline performance through the initiation of an intervention strategy. The intervention referred pregnant members due for prenatal care visits to CHWs for intensive outreach and engagement. [**Quality**, **Access**, and **Timeliness**]

Weaknesses and Recommendations

Weakness #1: Priority Health Choice did not achieve the state-defined goal for the PIP, and both performance indicators demonstrated non-statistically significant declines in performance as compared to the baseline. [**Quality**, **Access,** and **Timeliness**]

Why the weakness exists: While it is unclear why the goal was not achieved or why the performance indicators declined, the data suggest that barriers exist for both populations in the receipt of timely prenatal care.

Recommendation: HSAG recommends that **Priority Health Choice** revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance.

Performance Measure Validation

Performance Results

Priority Health Choice was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2022 Compliance Audit Report findings, **Priority Health Choice** was fully compliant with all seven IS standards.

According to the auditor's review, **Priority Health Choice** followed the NCQA HEDIS MY 2022 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-85 displays the MDHHS-selected performance measures, HEDIS MY 2021 and MY 2022 rates, MY 2021 and MY 2022 comparisons, and MY 2022 performance levels based on comparisons to national percentiles[3-45] for **Priority Health Choice**. Additional performance measures and performance measure results for **Priority Health Choice** can be referenced in Appendix B.

Table 3-85—HEDIS MY 2022 Performance Measure Results for PRI

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	59.18%	53.15%	**-6.03⁺⁺**	★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	65.58%	59.86%	**-5.72⁺⁺**	★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	60.53%	61.72%	+1.19⁺	★★★
Ages 12 to 17 Years	51.89%	51.71%	-0.18	★★★
Ages 18 to 21 Years	30.06%	29.23%	-0.83	★★★
Total	52.67%	52.87%	+0.20	★★★
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	60.52%	57.75%	**-2.77⁺⁺**	★★★
Ages 21 to 24 Years	66.59%	65.55%	-1.04	★★★
Total	63.39%	61.47%	**-1.92⁺⁺**	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	63.99%	61.31%	-2.68	★★★

[3-45] HEDIS MY 2022 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2021 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Breast Cancer Screening				
Breast Cancer Screening	56.52%	53.81%	-2.71++	★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)**	34.31%	30.41%	-3.90	★★★★★
HbA1c Control (<8.0%)	55.72%	57.66%	+1.94	★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	61.31%	54.48%	-6.83++	★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	69.59%	68.61%	-0.98	★★★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	34.91%	35.93%	+1.02	★★★
Ages 65 to 74 Years	34.09%	39.29%	+5.20	★★★
Ages 75 to 85 Years	29.77%	41.40%	+11.63+	★★★
Total	34.79%	36.20%	+1.41+	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	66.42%	73.24%	+6.82+	★★★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Priority Health Choice's performance ranked at or above the 90th percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure

indicator and between the 75th and 89th percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicator, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-46] [**Quality** and **Access**]

Strength #2: Priority Health Choice's performance ranked between the 75th and 89th percentile for the *Blood Pressure Control for Patients With Diabetes* measure indicator, indicating that members with diabetes had controlled blood pressure most of the time. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-47] [**Quality** and **Access**]

Strength #3: Priority Health Choice's performance ranked at or above the 90th percentile for the *Controlling High Blood Pressure* measure, which is a significant improvement from the prior year, indicating that members with a diagnosis of hypertension had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-48] [**Quality** and **Access**]

Strength #4: Priority Health Choice demonstrated overall strength in its HEDIS data reporting, as **Priority Health Choice** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Priority Health Choice's performance for *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, ranked between the 25th and 49th percentile and below the 25th percentile, respectively, indicating children who turned 15 months old during the measurement year were not having at least six well-child visits with a PCP during their first 15 months of life. Additionally, that children who turned 30 months old during the measurement year were not having at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence the health and development of a child, and they are a critical opportunity for screening and counseling.[3-49] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rates for *Well-Child Visits in the First 30 Months of Life* measure indicators, *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child*

[3-46] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.
[3-47] American Academy of Family Physicians. Effects of Intensive Blood Pressure Control in Patients with Diabetes Mellitus. Available at: https://www.aafp.org/pubs/afp/issues/2011/0301/p612a.html. Accessed on: Mar 7, 2024.
[3-48] National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Mar 7, 2024.
[3-49] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits, ranked between the 25th and 49th percentile and below the 25th percentile, respectively. Barriers noted by **Priority Health Choice** included incorrect contact information for members, unengaged members, provider capacity, and SDOH experienced by members.

Recommendation: While **Priority Health Choice** noted several interventions currently in place to target improvement, such as member outreach via email or letter, distributing a provider newsletter that includes preventive screening requirements, and developing partnerships with various community agencies, performance for the *Well-Child Visits in the First 30 Months of Life* measure remains low. Therefore, HSAG recommends that **Priority Health Choice** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Compliance Review

Performance Results

Table 3-86 presents the total number of criteria for each standard that received a score of *Met*, *Satisfied*, or *Not Met*. Table 3-86 also presents **Priority Health Choice**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. **Priority Health Choice** was subject to a corrective action review process outlined in Appendix A.

Table 3-86—Compliance Review Results for PRI

Standard		Number of Scores			Compliance Scores	
		Met	*Satisfied*[1]	*Not Met*	PRI[2]	Statewide[3]
1	Administrative	5	0	0	100%	100%
2	Providers	22	0	1	96%	94.7%
3	Members	28	0	1	97%	97.7%
4	Quality	22	0	0	100%	99.5%
5	MIS/Financial	39	1	0	98%	96.1%
6	OIG/Program Integrity	27	0	8	77%	90.2%
Overall		**143**	**1**	**10**	**93%**	**95.5%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

[2] MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

[3] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **Priority Health Choice** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Priority Health Choice achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: Priority Health Choice achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs; QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: While **Priority Health Choice** demonstrated high performance overall (i.e., 90 percent or high but less than 100 percent) in the Members standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for element *3.6 – A Member Appeals*. [**Timeliness** and **Access**]

Why the weakness exists: Priority Health Choice did not submit the required member-level detail for several appeals that were not resolved timely. The MHP reported that this was an administrative error and misunderstanding due to new reporting requirements and the complexity involved in reporting cases utilizing new templates.

Recommendation: Priority Health Choice was required to submit a CAP to address element 3.6, which was approved by MDHHS. As such, HSAG recommends that **Priority Health Choice** continue to implement action plans and monitoring processes to ensure all appeals are resolved timely.

Weakness #2: Priority Health Choice demonstrated poorer performance overall (i.e., less than 80 percent) in the OIG/Program Integrity standard and scored below the statewide average. The MHP received a *Not Met* score for elements *6.1* Quarterly *Program Integrity Forms – Tips and Grievances – FY22 Q3*, *6.2 Quarterly Program Integrity Forms – Data Mining – FY22 Q2*, *6.2 Quarterly*

Program Integrity Forms – Data Mining – FY22 Q3, *6.3 Quarterly Program Integrity Forms – Audits – FY22 Q2*, *6.3 Quarterly Program Integrity Forms – Audits – FY22 Q3*, *6.8 – Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY21 Q4*, *6.8 – Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY22 Q1*, and *6.8 – Quarterly OIG Program Integrity Forms – Encounter Adjustments – FY22 Q2*. [**Quality**]

Why the weakness exists: MDHHS identified multiple data errors across several reporting forms. **Priority Health Choice** reported several causes for the errors, including, but not limited to, staff transitions, misinterpretation of reporting guidance and validation processes, human/manual error, and need for updated reporting logic.

Recommendation: **Priority Health Choice** was required to submit CAPs to address elements 6.1, 6.2, 6.3, and 6.8, which were approved by MDHHS. As such, HSAG recommends that **Priority Health Choice** continue to implement action plans and monitoring processes for noncompliant elements under the OIG/Program Integrity standard to ensure all data reported for program integrity purposes are accurate (i.e., *Tips and Grievances*, *Date Mining*, *Audits*, and *Encounter Adjustments* data).

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 319 cases by comparing provider data that **Priority Health Choice** submitted to HSAG against **Priority Health Choice**'s online provider directory. The sample included 153 PCPs, 153 pediatric providers, and 13 OB/GYN providers (Table 3-87). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 96.6 percent (n=308) of the reviews. The sampled providers were not found in the online provider directory in 3.4 percent (n=11) of the reviewed cases.

Table 3-87—Summary of Providers Present in the Directory by Provider Category

		Providers Found in Directory		Providers Not Found in Directory	
Provider Category	Number of Sampled Providers	Count	%	Count	%
PCPs	153	145	94.8%	8	5.2%
Pediatric Providers	153	150	98.0%	3	2.0%
OB/GYN Providers	13	13	100%	0	0.0%
PRI Total	**319**	**308**	**96.6%**	**11**	**3.4%**

Table 3-88 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Priority Health Choice**'s provider data submission to HSAG and **Priority Health Choice**'s online provider directory.

Table 3-88—Provider Demographic Indicators Matching Online Provider Directory

	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%	Count	%
Provider's Name	145	100%	150	100%	13	100%	308	100%
Provider Street Address	144	99.3%	142	94.7%	13	100%	299	97.1%
Provider Suite Number	144	99.3%	146	97.3%	13	100%	303	98.4%
Provider City	145	100%	144	96.0%	13	100%	302	98.1%
Provider State	145	100%	148	98.7%	13	100%	306	99.4%
Provider ZIP Code	145	100%	143	95.3%	13	100%	301	97.7%
Provider Telephone Number	119	82.1%	91	60.7%	9	69.2%	219	71.1%
Provider Type/Specialty	143	98.6%	150	100%	13	100%	306	99.4%
Provider Accepting New Patients	141	97.2%	149	99.3%	13	100%	303	98.4%
Provider Gender	145	100%	150	100%	13	100%	308	100%
Provider Primary Language*	145	100%	140	93.3%	13	100%	298	96.8%
Non-English Language Speaking Provider (including American Sign Language)*	106	73.1%	147	98.0%	5	38.5%	258	83.8%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 217 sampled provider locations (i.e., "cases") for **Priority Health Choice**, with an overall response rate of 55.8 percent (n=121). Table 3-89 summarizes the secret shopper survey results for **Priority Health Choice**.

Table 3-89—Summary of PRI Secret Shopper Survey Results

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
PCPs	118	75	63.6%	57	76.0%	55	73.3%	43	57.3%	35	46.7%
Pediatric Providers	90	38	42.2%	30	78.9%	29	76.3%	24	63.2%	13	34.2%
OB/GYN Providers	9	8	88.9%	8	100%	8	100%	7	87.5%	7	87.5%
PRI Total	**217**	**121**	**55.8%**	**95**	**78.5%**	**92**	**76.0%**	**74**	**61.2%**	**55**	**45.5%**

Table 3-90 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Priority Health Choice**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-90—Appointment Availability Results

			Cases Offered an Appointment			Appointment Wait Time (Days)				
Provider Category	Total Survey Cases	Cases Accepting New Patients	Count	Rate Among All Surveyed Cases[1] (%)	Rate Among Cases Accepting New Patients[2] (%)	Min	Max	Average	Median	Percentage of Cases Within Standard[3]
PCPs	118	30	20	16.9%	66.7%	1	65	25	24	60.0%
Pediatric Providers	90	12	6	6.7%	50.0%	2	79	36	34	50.0%
OB/GYN Providers	9	7	2	22.2%	28.6%	11	13	12	12	0.0%
PRI Total	**217**	**49**	**28**	**12.9%**	**57.1%**	**1**	**79**	**27**	**19**	**53.6%**

[1] The denominator includes all surveyed cases included in the sample.
[2] The denominator includes cases responding to the survey that accept the insurance and new patients.
[3] The denominator includes cases offered an appointment. The MDHHS appointment timeliness standards are 30 business days for routine care appointments and seven business days for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the 96.6 percent of providers that reviewers located in **Priority Health Choice**'s online provider directory, 10 of 12 indicators had match rates above 95 percent. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Only 55.8 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **Priority Health Choice**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **Priority Health Choice** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of the locations reached, only 78.5 percent confirmed affiliation with the sampled provider. Additionally, 76.0 percent confirmed accuracy of the sampled address, 61.2 percent confirmed the services were offered, and 45.5 percent confirmed the requested insurance was accepted. [**Quality** and **Access**]

Why the weakness exists: **Priority Health Choice**'s provider data included invalid provider, specialty, and insurance information.

Recommendation: HSAG recommends that **Priority Health Choice** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

Weakness #3: Of the cases responding to the survey and accepting the insurance and new patients, only 57.1 percent of locations offered an appointment date. However, PCPs had an appointment availability rate of 66.7 percent, pediatric providers had an appointment availability rate of 50.0 percent, while OB/GYN provider locations had an appointment availability rate of 28.6 percent. [**Access**]

Why the weakness exists: For new **Priority Health Choice** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included

pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Priority Health Choice** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Priority Health Choice** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **Priority Health Choice** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Priority Health Choice**'s original questionnaire responses, and **Priority Health Choice** responded to these specific questions. To support its questionnaire responses, **Priority Health Choice** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Priority Health Choice** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-91 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-91—EDV Results for PRI

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Priority Health Choice** utilized Facets and Edifecs as its primary software for claim adjudication and encounter preparation. • **Priority Health Choice** had processes in place to detect and identify duplicate claims. **Priority Health Choice** clarified that it did not submit member ineligibility, services that were invalid for dental, pharmacy reversals, among other categories. In cases requiring adjustments, the claim frequency code "7" was used to indicate an adjusted encounter.

Analysis	Key Findings
	• **Priority Health Choice** and its subcontractors were responsible for collecting and maintaining provider information. Additionally, **Priority Health Choice** managed enrollment data received from MDHHS through 834 files, providing daily Medicaid enrollment updates to the MHPs for integration into their claim processing systems. **Priority Health Choice** ensured that subcontractors also received and incorporated these enrollment details into their respective claim systems.
Payment Structures	• **Priority Health Choice** used the DRG method as well as the APC and CMS pricing methods for its claim payment in inpatient encounters. Additionally, for outpatient and pharmacy encounters, it utilized line-by-line and percentage based on client contract and drug type methods, respectively. • In general, **Priority Health Choice** processed claims with TPL based on the collected insurance coverage information. When a claim suggests the existence of additional primary insurance for a member, the MHP's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details.
Encounter Data Quality Monitoring	• **Priority Health Choice** and/or its subcontractors performed several data quality checks on the encounter data collected by the subcontractors. These checks included, but were not limited to, analyzing claim volume by submission month (for all subcontractor encounters), assessing field-level completeness and validity (for all subcontractor encounters except medical), evaluating timeliness (for pharmacy), and ensuring alignment between payment fields in claims and financial reports (for dental and pharmacy encounters). • For encounters collected by **Priority Health Choice**, it conducted field-level completeness and validity and timeliness checks.
Administrative Profile	
Encounter Data Completeness	• **Priority Health Choice** displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • **Priority Health Choice** had a low volume of duplicate encounters, with less than 0.1 percent of professional encounters, less than 0.1 percent of institutional encounters, 0.6 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative.

Analysis	Key Findings
Encounter Data Timeliness	• **Priority Health Choice** demonstrated timely submission of professional, institutional, and dental encounters. Within 30 days, **Priority Health Choice** submitted 99.7 percent of professional encounters to MDHHS after the payment date. • Within 30 days, **Priority Health Choice** submitted 95.3 percent of institutional encounters to MDHHS after the payment date, and within 180 days, it submitted 99.7 percent of encounters. • Within 60 days, **Priority Health Choice** submitted 99.5 percent of dental encounters to MDHHS after the payment date. • **Priority Health Choice** did not demonstrate timely submission of pharmacy encounters, with 18.9 percent of pharmacy encounters submitted to MDHHS within 30 days of the payment date. Within 360 days, **Priority Health Choice** remained consistent with 19.0 percent of pharmacy encounters submitted to MDHHS after the payment date. However, **Priority Health Choice**'s submitted data had the submit date prior to the payment date for 80.9 percent of pharmacy encounters.
Field-Level Completeness and Accuracy	• In **Priority Health Choice**'s submitted pharmacy encounters, the submit date was valid 19.1 percent of the time. • All other data elements in **Priority Health Choice**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Priority Health Choice**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the enrollment data. • Of all identified member IDs in **Priority Health Choice**'s submitted pharmacy data, 99.9 percent were identified in the enrollment data. • Of all identified provider NPIs in **Priority Health Choice**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. • Of all identified provider NPIs in **Priority Health Choice**'s submitted pharmacy encounter data, 96.2 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Priority Health Choice**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Priority Health Choice demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The MHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Priority Health Choice submitted professional, institutional, and dental encounters in a timely manner from the payment date, with about 95 percent of all encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all categories of service, key data elements for **Priority Health Choice** were populated at high rates and generally greater than 95 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Priority Health Choice did not indicate encounter completeness checks performed for claims/encounters stored in its data warehouses. [**Quality**]

Why the weakness exists: Only field-level completeness and accuracy and timeliness were listed as being conducted, and no check for completeness at the encounter level was mentioned.

Recommendation: Priority Health Choice should build a comprehensive set of monitoring reports at the encounter level to evaluate encounter data accuracy, completeness, and timeliness for encounters collected by **Priority Health Choice**.

Weakness #2: Approximately 81 percent of **Priority Health Choice** pharmacy encounters had a submit date prior to the payment date. [**Quality**]

Why the weakness exists: Inaccurate date fields can lead to inaccurate timeliness metrics.

Recommendation: Priority Health Choice should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date is after the payment date field.

Weakness #3: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 96 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: **Priority Health Choice** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-92 presents **Priority Health Choice**'s 2022 and 2023 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-92—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for PRI

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Global Ratings				
Rating of Health Plan	66.67%	61.72%	70.74%	69.83%
Rating of All Health Care	61.84%	52.00%	72.95%	67.07%
Rating of Personal Doctor	65.52%	64.80%	77.99%	75.85%
Rating of Specialist Seen Most Often	75.47%	60.20%+ ▼	72.50%+	72.22%+
Composite Measures				
Getting Needed Care	84.78%	83.70%	86.60%+	93.49% ↑
Getting Care Quickly	85.81%	90.11%+ ↑	89.63%+	90.60%
How Well Doctors Communicate	92.93%	93.49%	95.29%	96.36% ↑
Customer Service	90.40%+	92.35%+	86.84%+	94.10%+ ↑
Individual Item Measure				
Coordination of Care	92.13%+	91.78%+ ↑	87.76%+	91.43%+ ↑
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	76.92%	74.80%	—	—
Discussing Cessation Medications	49.42%	51.56%	—	—
Discussing Cessation Strategies	44.71%	40.77%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.

▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Priority Health Choice's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national average for two measures: *Getting Care Quickly* and *Coordination of Care*. [**Quality** and **Timeliness**]

Strength #2: Priority Health Choice's 2023 top-box scores were statistically significantly higher than the 2022 NCQA child Medicaid national average for four measures: *Getting Needed Care, How Well Doctors Communicate, Customer Service*, and *Coordination of Care*. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Priority Health Choice's 2023 top-box score was statistically significantly lower than the 2022 adult Medicaid top-box score for one measure, *Rating of Specialist Seen Most Often*. [**Quality**]

Why the weakness exists: The results indicate that **Priority Health Choice** members are reporting a more negative experience with their specialist. However, HSAG is unable to identify the MHP-specific barriers or other factors impacting drivers for this measure based on the information provided through this EQR.

Recommendation: HSAG recommends that **Priority Health Choice** continue to explore what may be driving the lower experience score, develop initiatives designed to improve quality of care, and focus on improving members' overall experiences with their specialist. **Priority Health Choice** should determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the MHP that could be contributing to a lack of network adequacy and access issues.

Performance Results—CSHCS

Table 3-93 presents **Priority Health Choice**'s 2022 and 2023 CSHCS CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-93—Summary of CSHCS CAHPS Survey Top-Box Scores for PRI

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	73.08%	67.62%
Rating of Health Care	72.22%	65.87% NA
Rating of Specialist Seen Most Often	78.06%	70.06%
Rating of CMDS Clinic	88.00%+	70.59%+ NA
Composite Measures		
Customer Service	98.04%+	85.96%+ ▼ NA
How Well Doctors Communicate	96.30%	93.89% NA
Access to Specialized Services	70.15%+	72.60%+ NA
Transportation	87.12%+	70.54%+ NA
Individual Item Measures		
Access to Prescription Medicines	93.41%	91.71%
CMDS Clinics	96.00%+	87.50%+ NA
Local Health Department Services	78.85%+	76.67%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	97.18%	97.47% NA
Not Felt Treated Unfairly: Health Insurance Type	96.02%	94.44% NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an

identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Priority Health Choice's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Priority Health Choice's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for one measure, *Customer Service.* [**Quality**]

Why the weakness exists: When compared to 2022 top-box scores, the results indicate that **Priority Health Choice**'s parents/caregivers are reporting a more negative experience with their child's health plan's customer service. **Priority Health Choice** customer service staff may not be providing the information parents/caregivers of child members need or treating them with courtesy and respect.

Recommendation: HSAG recommends that **Priority Health Choice** conduct an evaluation of current MHP call center hours and practices to determine if the hours and resources meet members' needs. **Priority Health Choice** could further promote the use of existing after-hours customer service to improve customer service results. Furthermore, **Priority Health Choice** could appoint workgroups from call center staff members to discuss and refine existing service standards to enhance staff interactions with members.

Performance Results—HMP

Table 3-94 presents **Priority Health Choice**'s 2022 and 2023 HMP CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-94—Summary of HMP CAHPS Top-Box Scores for PRI

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	59.92%	63.81%
Rating of All Health Care	57.14%	56.45%
Rating of Personal Doctor	67.36%	67.88%
Rating of Specialist Seen Most Often	69.79%+	61.73%+
Composite Measures		
Getting Needed Care	83.72%	85.41%

	2022 Top-Box Score	2023 Top-Box Score
Getting Care Quickly	80.08%	82.64%
How Well Doctors Communicate	91.58%	93.62%
Customer Service	83.81%+	90.48%+
Individual Item Measure		
Coordination of Care	86.67%+	89.61%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	75.74%	72.31%
Discussing Cessation Medications	56.80%	53.44%
Discussing Cessation Strategies	47.93%	45.80%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.

Strengths, Weaknesses, and Recommendations—HMP

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Priority Health Choice's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: Priority Health Choice's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Priority Health Choice** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide, which is inclusive of **Priority Health Choice**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **Priority Health Choice**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Priority Health Choice** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Priority Health Choice**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-95 displays each applicable performance area and the overall performance impact related to the quality, timeliness, and accessibility of healthcare services provided to **Priority Health Choice**'s Medicaid members.

Table 3-95—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access**—**Priority Health Choice** continued its MDHHS-mandated PIP focused on disparities in timeliness of prenatal care between its African American population and Caucasian population. Among several interventions, one of **Priority Health Choice**'s interventions was the PriorityMOM program, which engages pregnant women to provide resources for a healthy pregnancy and postpartum period. **Priority Health Choice** also appropriately implemented an intervention specific to the disparate population (African American members), Strong Beginnings. Additionally, **Priority Health Choice** met MDHHS' expectations for addressing health disparities through population health management as demonstrated by a 100 percent compliance score for the Quality standard; and specifically, a *Met* score for element *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*, demonstrating that it had adequate policies and procedures for providing population health management services. **Priority Health Choice** should continue to conduct data analysis through its quality program to identify and subsequently implement interventions to reduce disparities in healthcare. However, despite the implementation of appropriate interventions and although not statistically significant, **Priority Health Choice**'s rate for *Timeliness of Prenatal Care* for African American pregnant women decreased by 3.6 percentage points from the baseline measurement. Additionally, while not statistically significant, the comparison population of **Priority Health Choice**'s PIP, Caucasian pregnant women, demonstrated a decline of 0.7 percentage points. Opportunities for improving the timeliness of prenatal care

Performance Area	Overall Performance Impact
	is also supported by the results of the HEDIS audit documented within the 2023 HEDIS Aggregate Report for Michigan Medicaid located in Appendix B. While the rate for the *Timeliness of Prenatal Care* measure increased by 1.22 percentage points compared to the prior year, the rate ranked below the 25th Medicaid Quality Compass percentile. Prenatal care during the first trimester can lower the risk of pregnancy complications. **Priority Health Choice** should explore what may be decreasing this performance and consider if its African-American members may be experiencing additional barriers, or if other disparities exist within the data (i.e., geographic location) that should be targeted for improvement. Further, the results of the NAV activity indicate that some of **Priority Health Choice**'s members may be experiencing challenges contacting or scheduling appointments with OB/GYN providers due to invalid information within the provider directory, including provider telephone number and provider accepting insurance information. Lastly, of providers responding to the survey and accepting the insurance and new patients, only 28.6 percent of OB/GYN providers offered an appointment and neither of the two OB/GYN providers who offered an appointment met MDHHS' appointment timeliness standard of 30 business days. **Priority Health Choice** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members to further ensure members are able to obtain timely prenatal care, and to educate providers on appointment timeliness requirements.
Preventive Care	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity confirmed opportunities for **Priority Health Choice** to improve access to preventive care. Both rates for the *Well-Child Visits in the First 30 Months of Life* ranked either below the 25th Medicaid Quality Compass percentile or between the 25th and 49th percentile and demonstrated a statistically significant decline from the prior year. Well-child visits are necessary for physicians to screen for any medical problems, including psychosocial concerns, provide guidance to parents, and promote better health outcomes. Additionally, the results of the NAV activity indicate that some of **Priority Health Choice**'s members may be experiencing challenges making appointments with PCPs or pediatric providers due to inaccurate information within **Priority Health Choice**'s provider directory, and provider offices informing members that they do not accept **Priority Health Choice** Medicaid insurance. Further, of providers responding to the survey and accepting the insurance and new patients, only 66.7 and 50 percent of PCPs and pediatric providers, respectively, offered an appointment; and of the providers who offered a routine appointment, only 60 percent of PCPs and 50 percent of pediatric providers offered the appointment timely (i.e., within MDHHS' appointment time frame of 30 business days.) **Priority Health Choice** should use the results of the NAV activity and internal monitoring mechanisms to

Performance Area	Overall Performance Impact
	improve the accuracy of provider information that is available to members, and to educate providers on appointment timeliness requirements. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from its prior year or to the national average, the rates ranged from 64.80 percent to 75.85 percent. **Priority Health Choice** should also consider these results when determining potential barriers for members accessing preventive care due to dissatisfaction with their PCP. However, although several of the rates for preventive care measures declined from the prior year's rates, five of them significantly, **Priority Health Choice** also demonstrated strengths related to preventive care. All rates for the *Child and Adolescent Well-Care Visits* and *Chlamydia Screening in Women* measures as well as the rate for *Cervical Cancer Screening* and *Breast Cancer Screening* measures ranked between the 50th and 74th Medicaid Quality Compass percentile. Regular checkups and screenings can lead to early detection and treatment of cervical and breast cancers and reduce the occurrence of serious complications. As compared to national percentiles, **Priority Health Choice** is performing well under the Women—Adult Care domain; however, **Priority Health Choice** should monitor these measures for continued decline in rates and implement initiatives should a negative trend be identified. Further, as demonstrated through the compliance review, **Priority Health Choice** met MDHHS' expectations for monitoring appointment wait times for preventive services. Specifically, **Priority Health Choice** received a *Met* score for element *2.10 Provider Wait Times* under the Providers standard, which included but was not limited to monitoring of the following metrics: *Routine Care is available within 30 Business Days of request*, *Routine Dental Care is within 21 Business Days of request*, and *Preventive Dental Services is within six weeks of request*.
Care for Chronic Conditions	**Quality**, **Timeliness**, and **Access**—Overall, **Priority Health Choice** demonstrated mostly positive results across the EQR activities pertaining to chronic conditions. The PMV activity results confirmed that **Priority Health Choice** met the 90th Medicaid Quality Compass percentile for one rate for the *Hemoglobin A1c Control for Patients With Diabetes* and *Controlling High Blood Pressure* measures. Additionally, the other rate for *Hemoglobin A1c Control for Patients With Diabetes* measure and the rate for the *Blood Pressure Control for Patients With Diabetes* measure ranked between the 75th and 90th Medicaid Quality Compass percentile. Further, the rate for the *Eye Exam for Patients With Diabetes* measure and all rates for the *Kidney Health Evaluation for Patients With Diabetes* measure ranked between the 50th and 74th Medicaid Quality Compass percentile. These results indicate that more of **Priority Health Choice**'s members were receiving care to manage their chronic conditions. Appropriate management of chronic conditions can reduce

Performance Area	Overall Performance Impact
	symptoms and the chance of serious complications and improve quality of life. Further, as demonstrated by a *Met* score for element *3.10 CSHCS PCP Requirements* under the Members standard of the compliance review, **Priority Health Choice** met MDHHS' expectations for assignment of PCPs for children and youth with complex chronic conditions. However, the results of the NAV activity indicate that some of **Priority Health Choice**'s members may be experiencing challenges making appointments with PCPs due to inaccurate provider directory information and PCPs indicating that they do not accept **Priority Health Choice** Medicaid insurance or new patients. Additionally, of providers responding to the survey and accepting the insurance and new patients, only 66.7 percent of PCPs offered an appointment and only 60 percent of the PCPs who offered an appointment met the MDHHS appointment timeliness standard of 30 business days. **Priority Health Choice** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged from 64.80 percent to 75.85 percent. **Priority Health Choice** should also consider these results when determining potential barriers for members accessing care for chronic conditions due to dissatisfaction with their PCP.
Health Information Systems and Technology	**Quality**, **Timeliness**, and **Access—Priority Health Choice** demonstrated strengths of its health information systems and technology through the PMV, compliance, and EDV activities. The PMV findings confirmed that **Priority Health Choice** was fully compliant with how it collected, stored, analyzed, and reported HEDIS data. All rates were *Reportable*, indicating that **Priority Health Choice** followed the NCQA technical specifications for the calculation of HEDIS performance measures. Additionally, **Priority Health Choice** scored above the statewide average for the MIS/Financial standard within the compliance review activity, with a score of 98 percent, indicating that it met MDHHS' expectations for most requirements pertaining to **Priority Health Choice**'s MIS. Further, through the EDV activity, **Priority Health Choice** demonstrated its capability to collect, process, and transmit encounter data to MDHHS; submit encounter data timely; and populate valid key data elements for all service categories. However, as **Priority Health Choice** did not indicate encounter completeness checks for claims/encounters stored in its data warehouses, it should consider building a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness for encounters collected by **Priority Health Choice**. Additionally, as approximately 81 percent of **Priority Health**

Performance Area	Overall Performance Impact
	Choice pharmacy encounters had a submit date prior to the payment date, **Priority Health Choice** should implement quality checks to ensure the submission date is after the payment date. Further, as fewer pharmacy provider NPIs were identified in provider data than medical and dental provider NPIs, **Priority Health Choice** should also collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers. Lastly, as demonstrated through the compliance review findings, **Priority Health Choice** was not fully compliant with the *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS* metrics under compliance review element *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. Therefore, **Priority Health Choice** should continue to implement action plans and monitoring processes to ensure all encounter performance standards are consistently met.

UnitedHealthcare Community Plan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2023 evaluated the technical methods of **UnitedHealthcare Community Plan**'s PIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG determined the overall methodological validity of the PIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-97 displays the overall validation rating, the baseline rate, Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-96—Overall Validation Rating for UNI

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Addressing Disparities in Timeliness of Prenatal Care	*Met*	Timeliness of prenatal care for African-American/Black members in Region 10	61.5%	59.2% ⇔		NA

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
NA = The MHP did not identify a disparity within its population; therefore, an assessment of an existing disparity during R1 is not applicable.
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MHP conducted accurate data analysis and interpretation of PIP results; overall confidence that the PIP produced significant evidence of improvement).

Due to its lack of an identified disparity, **UnitedHealthcare Community Plan** determined through data analysis that the focus for the PIP should be improving timeliness of prenatal care for its African-American/Black members who reside in Region 10, as this population was the lowest-performing subgroup. The overall goal is to achieve statistically significant improvement over the baseline performance for the subsequent remeasurement periods or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-97 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-97—Remeasurement 1 Barriers and Interventions for UNI

Barriers	Interventions
Access to quality care	MIHP referrals
Members—Access to prenatal care—SDOH	Mommy coach—perinatal CHWs
Members—Access to prenatal care	Healthy first steps—case management services to break down barriers
Providers—Providing prenatal care	Cultural competency training. Provider incentives to improve access and quality of care by closing gaps
Biomedical—Prenatal care models	Doula pilot and doula services
Health plan—Support of members and providers—health literacy	Babyscripts—provider and member education and incentives Member Advisory Group meetings with maternal health focus

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: UnitedHealthcare Community Plan initiated interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan did not demonstrate significant improvement over the baseline performance for the first remeasurement period, with the results demonstrating a non-statistically significant decrease in performance. [**Quality**, **Access,** and **Timeliness**]

Why the weakness exists: While it is unclear why the performance indicator declined in performance, the data suggest that barriers exist for the target population in the receipt of timely prenatal care.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** revisit its causal/barrier analysis to determine if any new barriers exist for selected population that require the development of targeted strategies to improve performance.

Performance Measure Validation

Performance Results

UnitedHealthcare Community Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2022 Compliance Audit Report findings, **UnitedHealthcare Community Plan** was fully compliant with all seven IS standards.

According to the auditor's review, **UnitedHealthcare Community Plan** followed the NCQA HEDIS MY 2022 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-98 displays the MDHHS-selected performance measures, HEDIS MY 2021 and MY 2022 rates, MY 2021 and MY 2022 comparisons, and MY 2022 performance levels based on comparisons to national percentiles[3-50] for **UnitedHealthcare Community Plan**. Additional performance measures and performance measure results for **UnitedHealthcare Community Plan** can be referenced in Appendix B.

Table 3-98—HEDIS MY 2022 Performance Measure Results for UNI

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	57.52%	63.74%	+6.22^{+}	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	58.08%	60.54%	+2.46^{+}	★★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	57.53%	57.05%	-0.48	★★★
Ages 12 to 17 Years	50.23%	50.53%	+0.30	★★
Ages 18 to 21 Years	32.09%	30.71%	**-1.38^{++}**	★★★
Total	50.60%	50.04%	**-0.56^{++}**	★★★
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	60.01%	59.47%	-0.54	★★★
Ages 21 to 24 Years	65.18%	63.50%	-1.68	★★★
Total	62.36%	61.33%	-1.03	★★★

[3-50] HEDIS MY 2022 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2021 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cervical Cancer Screening				
Cervical Cancer Screening	58.88%	58.88%	0.00	★★★
Breast Cancer Screening				
Breast Cancer Screening	51.15%	53.45%	+2.30+	★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)**	33.09%	33.09%	0.00	★★★★
HbA1c Control (<8.0%)	56.93%	59.12%	+2.19	★★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	55.47%	56.93%	+1.46	★★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	67.15%	75.18%	+8.03+	★★★★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	37.55%	40.62%	+3.07+	★★★★
Ages 65 to 74 Years	43.35%	51.15%	+7.80+	★★★★
Ages 75 to 85 Years	47.69%	57.46%	+9.77	★★★★★
Total	37.87%	41.30%	+3.43+	★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	64.72%	65.45%	+0.73	★★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: UnitedHealthcare Community Plan's performance ranked between the 75th and 89th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, indicating children who turned 15 months old during the measurement year were getting at least six well-child visits with a PCP during their first 15 months of life most of the time. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-51] [**Quality**, **Timeliness**, and **Access**]

Strength #2: UnitedHealthcare Community Plan's performance ranked between the 75th and 89th percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicator and at or above the 90th percentile for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure indicator, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-52] [**Quality** and **Access**]

Strength #3: UnitedHealthcare Community Plan's performance ranked between the 75th and 89th percentile for the *Eye Exam for Patients With Diabetes* measure indicator, indicating members with diabetes had an eye exam to screen or monitor for diabetic retinal disease most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-53] [**Quality** and **Access**]

Strength #4: UnitedHealthcare Community Plan's performance ranked at or above the 90th percentile for the *Blood Pressure Control for Patients With Diabetes* measure indicator, indicating members with diabetes had controlled blood pressure most of the time. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-54] [**Quality** and **Access**]

Strength #5: UnitedHealthcare Community Plan's performance ranked at or above the 90th percentile for the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* measure indicator and ranked between the 75th and 89th percentile for the *Ages 18 to 64 Years*, *Ages 65 to 74 Years*, and *Total* measure indicators, indicating members with diabetes received kidney health evaluations most of the time. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-55] [**Quality** and **Access**]

[3-51] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

[3-52] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.

[3-53] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.

[3-54] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.

[3-55] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Mar 7, 2024.

Strength #6: UnitedHealthcare Community Plan's performance ranked between the 75th and 89th percentile for the *Controlling High Blood Pressure* measure, indicating members with a diagnosis of hypertension had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-56] [**Quality** and **Access**]

Strength #7: UnitedHealthcare Community Plan demonstrated overall strength in its HEDIS data reporting, as **UnitedHealthcare Community Plan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan's performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-57] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th and 49th percentile, suggesting barriers exist for children who turned 30 months old during the measurement year to receive timely well-child visits.

Recommendation: While **UnitedHealthcare Community Plan** noted several interventions currently in place to target improvement, such as provider incentives for meeting the recommended visits, providing additional support for low-performing providers, and offering transportation assistance to address identified SDOH needs, performance remained low for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. Therefore, HSAG recommends that **UnitedHealthcare Community Plan** continue its efforts to improve performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #2: UnitedHealthcare Community Plan's performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator ranked between the 25th and 49th percentile, indicating some children were not always receiving one or more well-care visits during the measurement year. Well-care visits provide an opportunity for providers to influence health and

3-56 National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Mar 7, 2024.

3-57 National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

development, and they are a critical opportunity for screening and counseling.[3-58] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator ranked between the 25th and 49th percentile, suggesting barriers exist for some children ages 12 to 17 years to receive timely well-care visits.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** conduct a root cause analysis or focused study to determine why some children ages 12 to 17 years did not receive timely well-care visits. Upon identification of a root cause, **UnitedHealthcare Community Plan** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure.

Compliance Review

Performance Results

Table 3-99 presents the total number of criteria for each standard that received a score of *Met, Satisfied*, or *Not Met*. Table 3-99 also presents **UnitedHealthcare Community Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **UnitedHealthcare Community Plan** was subject to a corrective action review process outlined in Appendix A.

Table 3-99—Compliance Review Results for UNI

Standard		Number of Scores			Compliance Scores	
		Met	*Satisfied*[1]	*Not Met*	UNI[2]	Statewide[3]
1	Administrative	5	0	0	100%	100%
2	Providers	22	0	1	96%	94.7%
3	Members	29	0	0	100%	97.7%
4	Quality	22	0	0	100%	99.5%
5	MIS/Financial	40	0	0	100%	96.1%
6	OIG/Program Integrity	25	0	10	71%	90.2%
Overall		**143**	**0**	**11**	**93%**	**95.5%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

[2] MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

[3] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

[3-58] Ibid.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **UnitedHealthcare Community Plan** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: UnitedHealthcare Community Plan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #2: UnitedHealthcare Community Plan achieved full compliance in the Members standard, demonstrating the MHP maintained sufficient policies and procedures to support its membership, which included, but was not limited to, access to service authorization processes; care coordination procedures; fair grievance and appeal systems; member information materials such as the handbook, newsletters, and website; and choice of PCPs. [**Quality**, **Timeliness**, and **Access**]

Strength #3: UnitedHealthcare Community Plan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs; QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Strength #3: UnitedHealthcare Community Plan achieved full compliance in the MIS/Financial standard, demonstrating the MHP maintained a health information system that collected, analyzed, integrated, and reported data in various program areas and functions, including, but not limited to, provider data; member enrollment and disenrollment; financial statements and reports; third-party recovery and subrogation requests; the common formulary; provider enrollment; claims payment; grievance and appeal tracking; and quality reporting. [**Quality**]

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan demonstrated poorer performance overall (i.e., less than 80 percent) in the OIG/Program Integrity standard and scored below the statewide average. The MHP received a *Not Met* score for elements *6.1 Quarterly Program Integrity Forms – Tips and Grievances – FY21 Q4*, *6.1 Quarterly Program Integrity Forms – Tips and Grievances – FY22 Q2*, *6.2 Quarterly Program Integrity Forms – Data Mining – FY21 Q4*, *6.2 Quarterly Program Integrity*

Forms – Data Mining – FY22 Q2, 6.2 Quarterly Program Integrity Forms – Data Mining – FY22 Q3, 6.3 Quarterly Program Integrity Forms – Audits – FY21 Q4, *6.3 Quarterly Program Integrity Forms – Audits – FY22 Q2*, *6.3 Quarterly Program Integrity Forms – Audits – FY22 Q3, 6.4 Quarterly Program Integrity Forms – Provider Disenrollments – FY21 Q4,* and *6.8 – Quarterly OIG Program Integrity Forms – Encounter Adjustments FY22 Q2*. [**Quality**]

Why the weakness exists: MDHHS identified multiple data errors across several reporting forms. **UnitedHealthcare Community Plan** reported several causes for the errors, including but not limited to vacant positions, incorrect fields used, need for training on reporting guidance and validation processes, human error, incorrect data validation formulas, lack of clear process documentation, and lack of quality review prior to submissions.

Recommendation: UnitedHealthcare Community Plan was required to submit CAPs to address elements 6.1, 6.2, 6.3, 6.4, and 6.8, which were approved by MDHHS. HSAG recommends that **UnitedHealthcare Community Plan** continue to implement action plans and monitoring processes for noncompliant elements under the OIG/Program Integrity standard to ensure all data reported for program integrity purposes are accurate (i.e., *Tips and Grievances*, *Data Mining*, *Audits*, *Provider Disenrollments,* and *Encounter Adjustments* data).

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 290 cases by comparing provider data that **UnitedHealthcare Community Plan** submitted to HSAG against **UnitedHealthcare Community Plan**'s online provider directory. The sample included 180 PCPs and 110 pediatric providers (Table 3-100). For SFY 2023, the eligible population criteria were updated to limit to those providers with the PCP indicator, which reduced the number of eligible OB/GYN providers. Due to this change, no OB/GYN providers were sampled for **UnitedHealthcare Community Plan**. Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 94.1 percent (n=273) of the reviews. The sampled providers were not found in the online provider directory in 5.9 percent (n=17) of the reviewed cases.

Table 3-100—Summary of Providers Present in the Directory by Provider Category

		Providers Found in Directory		Providers Not Found in Directory	
Provider Category	Number of Sampled Providers	Count	%	Count	%
PCPs	180	168	93.3%	12	6.7%
Pediatric Providers	110	105	95.5%	5	4.5%
UNI Total	**290**	**273**	**94.1%**	**17**	**5.9%**

Table 3-101 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **UnitedHealthcare Community Plan**'s provider data submission to HSAG and **UnitedHealthcare Community Plan**'s online provider directory.

Table 3-101—Provider Demographic Indicators Matching Online Provider Directory

	PCPs		Pediatric Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%
Provider's Name	168	100%	105	100%	273	100%
Provider Street Address	156	92.9%	98	93.3%	254	93.0%
Provider Suite Number	168	100%	103	98.1%	271	99.3%
Provider City	159	94.6%	104	99.0%	263	96.3%
Provider State	167	99.4%	105	100%	272	99.6%
Provider ZIP Code	159	94.6%	102	97.1%	261	95.6%
Provider Telephone Number	153	91.1%	96	91.4%	249	91.2%
Provider Type/Specialty	164	97.6%	104	99.0%	268	98.2%
Provider Accepting New Patients	168	100%	105	100%	273	100%
Provider Gender	167	99.4%	105	100%	272	99.6%
Provider Primary Language*	168	100%	105	100%	273	100%
Non-English Language Speaking Provider (including American Sign Language)*	168	100%	102	97.1%	270	98.9%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 242 sampled provider locations (i.e., "cases") for **UnitedHealthcare Community Plan**, with an overall response rate of 58.7 percent (n=142). Table 3-102 summarizes the secret shopper survey results for **UnitedHealthcare Community Plan**.

Table 3-102—Summary of UNI Secret Shopper Survey Results

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
PCPs	149	78	52.3%	38	48.7%	36	46.2%	9	11.5%	6	7.7%
Pediatric Providers	93	64	68.8%	40	62.5%	37	57.8%	33	51.6%	29	45.3%
UNI Total	**242**	**142**	**58.7%**	**78**	**54.9%**	**73**	**51.4%**	**42**	**29.6%**	**35**	**24.6%**

Table 3-103 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **UnitedHealthcare Community Plan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-103—Appointment Availability Results

			Cases Offered an Appointment			Appointment Wait Time (Days)				
Provider Category	Total Survey Cases	Cases Accepting New Patients	Count	Rate Among All Surveyed Cases[1] (%)	Rate Among Cases Accepting New Patients[2] (%)	Min	Max	Average	Median	Percentage of Cases Within Standard[3]
PCPs	149	4	1	0.7%	25.0%	5	5	5	5	100%
Pediatric Providers	93	22	12	12.9%	54.5%	3	66	17	12	83.3%
UNI Total	**242**	**26**	**13**	**5.4%**	**50.0%**	**3**	**66**	**16**	**12**	**84.6%**

[1] The denominator includes all surveyed cases included in the sample.
[2] The denominator includes cases responding to the survey that accept the insurance and new patients.
[3] The denominator includes cases offered an appointment. The MDHHS appointment timeliness standards are 30 business days for routine care appointments and seven business days for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the 94.1 percent of providers that reviewers located in **UnitedHealthcare Community Plan**'s online provider directory, all 12 indicators had match rates above 90 percent. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Only 58.7 percent of the sampled provider locations could be reached. [**Access**]

Why the weakness exists: In addition to the limitations identified in Appendix A related to the secret shopper approach, **UnitedHealthcare Community Plan**'s provider data included invalid telephone or address information when contacting the office staff members.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

Weakness #2: Of the locations reached, only 54.9 percent confirmed affiliation with the sampled provider. Additionally, 51.4 percent confirmed accuracy of the sampled address, 29.6 percent confirmed the services were offered, and 24.6 percent confirmed the requested insurance was accepted. [**Quality** and **Access**]

Why the weakness exists: **UnitedHealthcare Community Plan**'s provider data included invalid provider, specialty, and insurance information.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.

Weakness #3: Of the cases responding to the survey and accepting the insurance and new patients, only 50.0 percent of locations offered an appointment date. However, pediatric providers had an appointment availability rate of 54.5 percent, while PCPs had an appointment availability rate of 25.0 percent. [**Access**]

Why the weakness exists: For new **UnitedHealthcare Community Plan** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **UnitedHealthcare Community Plan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **UnitedHealthcare Community Plan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **UnitedHealthcare Community Plan**'s original questionnaire responses, and **UnitedHealthcare Community Plan** responded to these specific questions. To support its questionnaire responses, **UnitedHealthcare Community Plan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **UnitedHealthcare Community Plan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-104 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-104—EDV Results for UNI

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **United Healthcare Community Plan** utilized OptumInsight and NEMIS as its primary software for claim adjudication and encounter preparation. • **United Healthcare Community Plan** had processes in place to detect and identify duplicate claims. **United Healthcare Community Plan** outlined that it submitted all encounters except for denied claims where the encounter would reject for the same reason. When adjustments were necessary, the claim frequency code "7" was used to indicate an adjusted encounter. • **United Healthcare Community Plan** and its subcontractors were responsible for collecting and maintaining provider information. Additionally, **United Healthcare Community Plan** managed enrollment data received from MDHHS through 834 files, providing daily Medicaid enrollment updates to the MHPs for integration into their claim processing systems. **United Healthcare Community Plan** ensured that subcontractors also received and incorporated these enrollment details into their respective claim systems.

Analysis	Key Findings
Payment Structures	• **United Healthcare Community Plan** utilized the variable per diem and DRG methods for claim payment in inpatient encounters. Additionally, for outpatient encounters, it employed the variable per diem method, along with an unspecified method. Pharmacy encounters were processed using the ingredient cost method. • In general, **United Healthcare Community Plan** processed claims with TPL based on the collected insurance coverage information. When a claim suggests the existence of additional primary insurance for a member, the MHP's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details.
Encounter Data Quality Monitoring	• **United Healthcare Community Plan** indicated it modified its subcontractors' encounters. • **United Healthcare Community Plan** and/or its subcontractors performed various data quality checks on the encounter data collected. These checks included, but were not limited to, analyzing claim volume by submission month (for all subcontractor encounter), assessing field-level completeness and validity (for all subcontractor encounters), evaluating timeliness (for laboratory and vision encounters), and ensuring alignment between payment fields in claims and financial reports (for all subcontractor encounters). • For encounters collected by **United Healthcare Community Plan**, it conducted EDI compliance edit checks, assessed field-level completeness and accuracy, verified the alignment of payment fields in claims with the financial reports, and examined encounter submission trends.
Administrative Profile	
Encounter Data Completeness	• **UnitedHealthcare Community Plan** displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • **UnitedHealthcare Community Plan** had a low volume of duplicate encounters, with 0.1 percent of professional encounters, less than 0.1 percent of institutional encounters, 0.4 percent of dental encounters, and less than 0.1 percent of pharmacy encounters identified as duplicative.
Encounter Data Timeliness	• **UnitedHealthcare Community Plan** demonstrated timely submission of professional and institutional encounters. Within 60 days, **UnitedHealthcare Community Plan** submitted 99.8

Analysis	Key Findings
	percent of professional encounters to MDHHS after the payment date. Within 90 days, **UnitedHealthcare Community Plan** submitted 97.9 percent of institutional encounters to MDHHS after the payment date, and within 180 days, it submitted 99.8 percent of institutional encounters. • **UnitedHealthcare Community Plan** did not demonstrate timely submission of dental encounters, submitting 83.1 percent of dental encounters within 90 days, 84.5 percent within 180 days, and 91.1 percent within 360 days to MDHHS after the payment date. • **UnitedHealthcare Community Plan** did not demonstrate timely submission of pharmacy encounters, with 1.1 percent of pharmacy encounters submitted to MDHHS within 30 days of the payment date. Within 360 days, **UnitedHealthcare Community Plan** remained consistent with 1.2 percent of pharmacy encounters submitted to MDHHS after the payment date. However, **UnitedHealthcare Community Plan**'s submitted data had the submit date prior to the payment date for 98.8 percent of pharmacy encounters.
Field-Level Completeness and Accuracy	• In **UnitedHealthcare Community Plan**'s submitted pharmacy encounters, the submit date was valid 1.2 percent of the time. • All other data elements in **UnitedHealthcare Community Plan**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **UnitedHealthcare Community Plan**'s submitted professional, institutional, and dental encounter data, 99.9 percent were identified in the enrollment data. • Of all identified member IDs in **UnitedHealthcare Community Plan**'s submitted pharmacy data, 99.9 percent were identified in the enrollment data. • Of all identified provider NPIs in **UnitedHealthcare Community Plan**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. • Of all identified provider NPIs in **UnitedHealthcare Community Plan**'s submitted pharmacy encounter data, 94.6 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **UnitedHealthcare Community Plan**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been

linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: UnitedHealthcare Community Plan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The MHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: UnitedHealthcare Community Plan submitted professional and institutional encounters in a timely manner from the payment date, with about 98 percent of all encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all categories of service, key data elements for **UnitedHealthcare Community Plan** were populated at high rates and generally greater than 95 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan modified encounters from its subcontractors before submitting them to MDHHS. [**Quality**]

Why the weakness exists: Since modifications were made to the subcontractors' encounters, it is essential to communicate these changes to each entity involved to maintain data integrity.

Recommendation: UnitedHealthcare Community Plan should collaborate with MDHHS to confirm that the identified changes do not require adjustments to be sent back to the subcontractors.

Weakness #2: Approximately 99 percent of **UnitedHealthcare Community Plan** pharmacy encounters had a submit date prior to the payment date. [**Quality**]

Why the weakness exists: Inaccurate date fields can lead to inaccurate timeliness metrics.

Recommendation: UnitedHealthcare Community Plan should determine the accuracy of the payment and submission date fields and implement quality checks to ensure the submission date is after the payment date field.

Weakness #3: Although **UnitedHealthcare Community Plan** submitted professional and institutional encounters in a timely manner, **UnitedHealthcare Community Plan** did not submit dental encounters timely. About 91 percent of dental encounters were submitted within 360 days of payment. [**Quality** and **Timeliness**]

Why the weakness exists: The timely submission of encounters is crucial to guarantee that conducted analyses include comprehensive data. Failure to submit encounters in a timely manner may lead to incomplete analyses and inaccurate results.

Recommendation: UnitedHealthcare Community Plan should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment.

Weakness #4: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 95 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: **UnitedHealthcare Community Plan** should collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-105 presents **UnitedHealthcare Community Plan**'s 2022 and 2023 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-105—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for UNI

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Global Ratings				
Rating of Health Plan	63.30%	62.64%	68.30%	68.65%
Rating of All Health Care	60.87%	62.18%	63.87%	69.57%
Rating of Personal Doctor	72.30%	62.33%	75.98%	72.90%
Rating of Specialist Seen Most Often	64.00%$^{+}$	69.41%$^{+}$	76.60%$^{+}$	67.31%$^{+}$
Composite Measures				
Getting Needed Care	79.79%$^{+}$	83.65%	80.88%$^{+}$	80.31%
Getting Care Quickly	79.54%$^{+}$	80.29%$^{+}$	79.82%$^{+}$	85.81%
How Well Doctors Communicate	93.10%	91.76%	94.04%	90.94%
Customer Service	91.71%$^{+}$	82.84%$^{+}$	82.77%$^{+}$	88.10%$^{+}$
Individual Item Measure				
Coordination of Care	88.06%$^{+}$	79.31%$^{+}$	89.58%$^{+}$	79.69%$^{+}$
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	79.19%	78.57%	—	—

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Discussing Cessation Medications	56.76%	61.26% ↑	—	—
Discussing Cessation Strategies	47.62%	51.85%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: UnitedHealthcare Community Plan's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Discussing Cessation Medications*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult and child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—CSHCS

Table 3-106 presents **UnitedHealthcare Community Plan**'s 2022 and 2023 CSHCS CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-106—Summary of CSHCS CAHPS Survey Top-Box Scores for UNI

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	65.11%	71.07%
Rating of Health Care	66.32%	66.67% NA
Rating of Specialist Seen Most Often	70.49%	73.85%
Rating of CMDS Clinic	72.73%+	68.09%+ NA
Composite Measures		
Customer Service	84.00%+	83.90%+ NA
How Well Doctors Communicate	95.25%	90.92% ▼ NA
Access to Specialized Services	69.99%+	76.47%+ NA
Transportation	61.09%+	79.29%+ NA
Individual Item Measures		
Access to Prescription Medicines	90.19%	88.26%
CMDS Clinics	91.30%+	85.71%+ NA
Local Health Department Services	74.47%+	80.36%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	95.65%	93.81% NA
Not Felt Treated Unfairly: Health Insurance Type	96.74%	91.75% ▼ NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: UnitedHealthcare Community Plan's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan's 2023 top-box scores were statistically significantly lower than the 2022 top-box score for two measures, *How Well Doctors Communicate* and *Not Felt Treated Unfairly: Health Insurance Type.* [**Quality**]

Why the weakness exists: While above 90 percent, when compared to the 2022 top-box scores, the results indicate that more **UnitedHealthcare Community Plan** parents/caregivers did not perceive they were receiving thorough communication from their child's doctors and felt their child was treated unfairly due to their child's insurance type.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** provide literature to doctors and other health providers containing guidelines for how they can ensure they explain things in a way that is easy for the member to understand and that they spend enough time with the member. The literature also could furnish advice concerning the importance of listening carefully to members and how clinicians can show respect for what the member has to say. Providers may not be communicating well with parents/caregivers of child members or spending adequate time with the member to provide the quality of care the member anticipates or expects to meet their or their child's healthcare needs.

Performance Results—HMP

Table 3-107 presents **UnitedHealthcare Community Plan**'s 2022 and 2023 HMP CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-107—Summary of HMP CAHPS Top-Box Scores for UNI

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	58.91%	56.94%
Rating of All Health Care	65.45%	56.78%
Rating of Personal Doctor	71.25%	65.45%
Rating of Specialist Seen Most Often	76.92%+	66.67%+
Composite Measures		
Getting Needed Care	89.29%+	79.18% ▼

	2022 Top-Box Score	2023 Top-Box Score
Getting Care Quickly	83.98%+	82.00%+
How Well Doctors Communicate	95.58%	91.64%
Customer Service	89.49%+	84.91%+
Individual Item Measure		
Coordination of Care	80.36%+	79.03%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	74.22%	71.79%
Discussing Cessation Medications	56.00%	51.28%
Discussing Cessation Strategies	45.31%	46.15%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.

Strengths, Weaknesses, and Recommendations—HMP

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: UnitedHealthcare Community Plan's 2023 top-box scores were not statistically significantly higher than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial strengths were identified.

Weaknesses and Recommendations

Weakness #1: UnitedHealthcare Community Plan's 2023 top-box score was statistically significantly lower than the 2022 top-box score for one measure, *Getting Needed Care*. [**Quality** and **Access**]

Why the weakness exists: When compared to the 2022 top-box scores, the results indicate that **UnitedHealthcare Community Plan** members may have difficulty obtaining the care, tests, or treatments they need.

Recommendation: HSAG recommends that **UnitedHealthcare Community Plan** conduct root cause analyses or focus studies to determine why its members are not getting the quality of care they need, or do not have access to care. **UnitedHealthcare Community Plan** could consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **UnitedHealthcare Community Plan** should implement appropriate interventions to improve the performance related to the care members need.

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide, which is inclusive of **UnitedHealthcare Community Plan**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **UnitedHealthcare Community Plan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **UnitedHealthcare Community Plan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **UnitedHealthcare Community Plan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-108 displays each applicable performance area and the overall performance impact related to the quality, timeliness, and accessibility of healthcare services provided to **UnitedHealthcare Community Plan**'s Medicaid members.

Table 3-108—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access**—**UnitedHealthcare Community Plan** continued its MDHHS-mandated PIP focused on disparities in timeliness of prenatal care. However, as **UnitedHealthcare Community Plan** was unable to identify a disparity, the MHP determined that the focus for the PIP is to improve timeliness of prenatal care for African-American/Black members who reside in Region 10 as this population was the lowest-performing subgroup. **UnitedHealthcare Community Plan**'s rate of African-American/Black women receiving timely prenatal care declined slightly from the baseline to the first remeasurement period. These results align with the results of the HEDIS audit documented within the 2023 HEDIS Aggregate Report for Michigan Medicaid located in Appendix B. **UnitedHealthcare Community Plan**'s rate for the *Timeliness of Prenatal Care* measure demonstrated a decline of 5.11 percentage points from the prior year, and it ranked below the 25th Medicaid Quality Compass percentile. These results indicate that many women are not receiving prenatal care within the first trimester. Prenatal care

Performance Area	Overall Performance Impact
	during the first trimester can lower the risk of pregnancy complications. Additionally, through its PIP, while **UnitedHealthcare Community Plan** identified barriers and corresponding interventions, they appear to be generalized to the MHP's entire pregnant member population and not specific to its target population (i.e., African-American/Black pregnant members residing in Region 10), which may have contributed to the lack of improvement in its performance indicator. **UnitedHealthcare Community Plan** should ensure its PIP, including barriers and interventions, has a strong focus on its defined target population (i.e., identify barriers specifically for African-American/Black pregnant women residing in Region 10 and implement interventions that are tailored to African-American/Black pregnant women residing in Region 10). However, **UnitedHealthcare Community Plan** met MDHHS' expectations for addressing health disparities through population health management as demonstrated by a 100 percent compliance score for the Quality standard and specifically a *Met* score for element *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*. **UnitedHealthcare Community Plan** demonstrated that it had adequate policies and procedures for providing population health management services. **UnitedHealthcare Community Plan** should continue to conduct data analysis through its quality program to identify and subsequently implement interventions to reduce disparities in healthcare.
Preventive Care	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity confirmed opportunities for **UnitedHealthcare Community Plan** to improve access to preventive care. One rate for the *Well-Child Visits in the First 30 Months of Life* measure and one rate for the *Child and Adolescent Well-Care Visits* measure ranked between the 25th and 49th Medicaid Quality Compass percentile. Well-child visits are necessary for physicians to screen for any medical problems, including psychosocial concerns, provide guidance to parents, and promote better health outcomes. Additionally, the results of the NAV activity indicate that some of **UnitedHealthcare Community Plan**'s members may be experiencing challenges making appointments with PCPs or pediatric providers due to inaccurate information within **UnitedHealthcare Community Plan**'s provider directory and provider offices informing members that they do not accept **UnitedHealthcare Community Plan** Medicaid insurance. Further, of providers responding to the survey and accepting the insurance and new patients, only 25 percent and 54.5 percent of PCPs and pediatric providers, respectively, offered an appointment; and of the providers who offered a routine appointment, only 83.3 percent of pediatric providers offered the appointment timely (i.e., within MDHHS' appointment time frame of 30 business days). **UnitedHealthcare Community Plan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy

Performance Area	Overall Performance Impact
	of provider information that is available to members and to educate providers on appointment timeliness requirements. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged from 62.33 percent to 72.90 percent. **UnitedHealthcare Community Plan** should also consider these results when determining potential barriers for members accessing preventive care due to dissatisfaction with their PCP. However, although several of the rates for preventive care measures declined from the prior year's rates, two of them significantly, **UnitedHealthcare Community Plan** also demonstrated strengths related to preventive care. One rate for the W*ell-Child Visits in the First 30 Months of Life* measure ranked between the 75th and 89th Medicaid Quality Compass percentile, and three rates for the *Child and Adolescent Well-Care Visits* measure, all rates for the *Chlamydia Screening in Women* measure, the rate for the *Cervical Cancer Screening* measure, and the rate for the *Breast Cancer Screening* measure ranked between the 50th and 74th Medicaid Quality Compass percentile. Regular checkups and screenings can lead to early detection and treatment of cervical and breast cancers and reduce the occurrence of serious complications. Further, as demonstrated through the compliance review, **UnitedHealthcare Community Plan** met MDHHS' expectations for monitoring appointment wait times for which preventive services are rendered. Specifically, **UnitedHealthcare Community Plan** received a *Met* score for element *2.10 Provider Wait Times* under the Providers standard, which included but was not limited to monitoring of the following metrics: *Routine Care is available within 30 Business Days of request*, *Routine Dental Care is within 21 Business Days of request*, and *Preventive Dental Services is within six weeks of request*.
Care for Chronic Conditions	**Quality**, **Timeliness**, and **Access**—Overall, **UnitedHealthcare Community Plan** demonstrated mostly positive results across the EQR activities pertaining to chronic conditions. The PMV activity results confirmed that **UnitedHealthcare Community Plan** met the 90th Medicaid Quality Compass percentile for one rate for the following measures: *Hemoglobin A1c Control for Patients With Diabetes*, *Blood Pressure Control for Patients With Diabetes*, and *Kidney Health Evaluation for Patients With Diabetes*. Additionally, the other rate for *Hemoglobin A1c Control for Patients With Diabetes* measure, the rate for the *Eye Exam for Patients With Diabetes* measure, the remaining rates for the *Kidney Health Evaluation for Patients With Diabetes* measure, and the rate for the *Controlling High Blood Pressure* measure ranked between the 75th and 90th Medicaid Quality Compass percentile. These results indicate that more of **UnitedHealthcare Community Plan**'s members were receiving care to manage their chronic conditions.

Performance Area	Overall Performance Impact
	Appropriate management of chronic conditions can reduce symptoms and the chance of serious complications and improve quality of life. Further, as demonstrated by a *Met* score for element *3.10 CSHCS PCP Requirements* under the Members standard of the compliance review, **UnitedHealthcare Community Plan** met MDHHS' expectations for assignment of PCPs for children and youth with complex chronic conditions. However, the results of the NAV activity indicate that some of **UnitedHealthcare Community Plan**'s members may be experiencing challenges making appointments with PCPs due to inaccurate provider directory information and PCPs indicating that they do not accept **UnitedHealthcare Community Plan** Medicaid insurance. Additionally, of providers responding to the survey and accepting the insurance and new patients, only 25 percent of PCPs offered an appointment. **UnitedHealthcare Community Plan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged from 62.33 percent to 72.90 percent. **UnitedHealthcare Community Plan** should also consider these results when determining potential barriers for members accessing care for chronic conditions due to dissatisfaction with their PCP.
Health Information Systems and Technology	**Quality**, **Timeliness**, and **Access—UnitedHealthcare Community Plan** demonstrated strengths of its health information systems and technology through the PMV, compliance, and EDV activities. The PMV findings confirmed that **UnitedHealthcare Community Plan** was fully compliant with how it collected, stored, analyzed, and reported HEDIS data. All rates were *Reportable*, indicating that **UnitedHealthcare Community Plan** followed the NCQA technical specifications for the calculation of HEDIS performance measures. Additionally, **UnitedHealthcare Community Plan** scored above the statewide average for the MIS/Financial standard within the compliance review activity, with a score of 100 percent, indicating that it met MDHHS' expectations for all requirements pertaining to **UnitedHealthcare Community Plan**'s MIS. Further, through the EDV activity, **UnitedHealthcare Community Plan** demonstrated its capability to collect, process, and transmit encounter data to MDHHS; submit professional and institutional encounter data timely; and populate valid key data elements for all service categories. Additionally, as demonstrated through the compliance review findings, **UnitedHealthcare Community Plan** achieved full compliance in the MIS/Financial standard, demonstrating the MHP maintained a health information system that collected, analyzed, integrated, and reported data in various program areas and functions.

Performance Area	Overall Performance Impact
	However, **UnitedHealthcare Community Plan** modified its subcontractors' encounters before submitting them to MDHHS. Since modifications were made to the subcontractors' encounters, it is essential that **UnitedHealthcare Community Plan** communicate these changes to each entity involved to maintain data integrity. Additionally, as approximately 99 percent of **UnitedHealthcare Community Plan** pharmacy encounters had a submit date prior to the payment date, **UnitedHealthcare Community Plan** should implement quality checks to ensure the submission date is after the payment date. Further, **UnitedHealthcare Community Plan** only submitted 91 percent of dental encounters timely; as such, **UnitedHealthcare Community Plan** should monitor its encounter data submission to MDHHS to ensure encounters are submitted after payment. Lastly, as fewer pharmacy provider NPIs were identified in provider data than medical and dental provider NPIs, **UnitedHealthcare Community Plan** should also collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Upper Peninsula Health Plan

Validation of Performance Improvement Projects

Performance Results

HSAG's validation for SFY 2023 evaluated the technical methods of **Upper Peninsula Health Plan**'s PIP, including an evaluation of statistically, clinically, or programmatically significant improvement based on reported results and statistical testing (i.e., Step 9—Outcomes stage). Based on its technical review, HSAG determined the overall methodological validity of the PIP for all three stages (i.e., Design, Implementation, and Outcomes) and assigned an overall validation rating (i.e., *Met*, *Partially Met*, *Not Met*). Table 3-109 displays the overall validation rating, the baseline rate, Remeasurement 1 results for the performance indicators, and if a disparity existed within the most recent measurement period.

Table 3-109—Overall Validation Rating for UPP

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results			
			Baseline	R1	R2	Disparity
Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members Ages 20–44	*Met*	1. Annual Ambulatory or Preventative Visit for UPP Black members.	64.7%	65.8% ⇔		Yes
		2. Annual Ambulatory or Preventative Visit for UPP White members.	77.4%	75.6% ↓		

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MHP conducted accurate data analysis and interpretation of PIP results; overall confidence that the PIP produced significant evidence of improvement).

The goals for **Upper Peninsula Health Plan**'s PIP are that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black members) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White members), or achieve clinically or programmatically significant improvement as a result of an intervention. Table 3-110 displays the barriers identified through quality improvement and causal/barrier analysis processes and the interventions initiated by the MHP to support achievement of the PIP goals and address the barriers.

Table 3-110—Remeasurement 1 Barriers and Interventions for UPP

Barriers	Interventions
Member lacks understanding of Medicaid benefits available, SDOH resources, and how programs work.	The MHP outreached members of the target population to perform a survey to identify barriers to completing care, along with education and coordination of care as needed.
Member lack of trust in healthcare system.	
Providers have difficulty getting new patients established.	The MHP offered an alternative payment method to select provider clinic systems to address and eliminate existing racial disparities for the performance indicator.
The MHP's lack of racial/ethnic diversity in network and lack of reporting of race/ethnicity by network providers.	The MHP worked with provider relations staff to increase provider reported race.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan initiated timely interventions that were reasonably linked to their corresponding barriers. The interventions were evaluated to determine the effectiveness of each effort, with decisions to continue, discontinue, or revise an effort being data driven. [**Quality**, **Timeliness**, and **Access**]

Strength #2: Upper Peninsula Health Plan demonstrated programmatically significant improvement over the baseline performance for the disparate population through the initiation of an intervention strategy. The intervention, telephonic member outreach, identified and addressed members' barriers and provided education on preventive care. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan did not achieve the state-defined goal of eliminating the existing disparity with the first remeasurement period, and the comparison group demonstrated a statistically significant decrease in performance as compared to the baseline. [**Quality**, **Access,** and **Timeliness**]

Why the weakness exists: While it is unclear why the goal was not achieved or why the comparison population declined in performance, **Upper Peninsula Health Plan** has made progress in improving performance for the disparate population.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** revisit its causal/barrier analysis to determine if any new barriers exist for both the disparate and comparison populations that require the development of targeted strategies to improve performance.

Performance Measure Validation

Performance Results

Upper Peninsula Health Plan was evaluated against NCQA's IS standards to measure how the MHP collected, stored, analyzed, and reported HEDIS data. According to the HEDIS MY 2022 Compliance Audit Report findings, **Upper Peninsula Health Plan** was fully compliant with all seven IS standards.

According to the auditor's review, **Upper Peninsula Health Plan** followed the NCQA HEDIS MY 2022 technical specifications and produced a *Reportable* rate for all included measures and sub-measures. No rates were determined to be materially biased.

Table 3-111 displays the MDHHS-selected performance measures, HEDIS MY 2021 and MY 2022 rates, MY 2021 and MY 2022 comparisons, and MY 2022 performance levels based on comparisons to national percentiles[3-59] for **Upper Peninsula Health Plan**. Additional performance measures and performance measure results for **Upper Peninsula Health Plan** can be referenced in Appendix B.

Table 3-111—HEDIS MY 2022 Performance Measure Results for UPP

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	67.53%	70.23%	+2.70	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	67.43%	68.09%	+0.66	★★★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	57.85%	56.40%	**-1.45++**	★★★
Ages 12 to 17 Years	51.87%	50.27%	-1.60	★★
Ages 18 to 21 Years	23.44%	23.73%	+0.29	★★
Total	49.99%	48.65%	**-1.34++**	★★
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	41.06%	43.20%	+2.14	★
Ages 21 to 24 Years	51.13%	48.69%	-2.44	★

[3-59] HEDIS MY 2022 performance measure rates are compared to NCQA's Quality Compass National Medicaid HMO percentiles for HEDIS MY 2021 (referred to as "percentiles" throughout this section of the report).

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Total	45.73%	45.75%	+0.02	★
Cervical Cancer Screening				
Cervical Cancer Screening	61.31%	61.80%	+0.49	★★★
Breast Cancer Screening				
Breast Cancer Screening	59.29%	59.84%	+0.55	★★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)**	33.33%	30.17%	-3.16	★★★★★
HbA1c Control (<8.0%)	55.47%	61.07%	+5.60	★★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	59.61%	60.83%	+1.22	★★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	82.48%	82.00%	-0.48	★★★★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	34.50%	36.10%	+1.60	★★★
Ages 65 to 74 Years	39.38%	36.67%	-2.71	★★★
Ages 75 to 85 Years	35.06%	29.58%	-5.48	★★
Total	34.98%	35.99%	+1.01	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	79.08%	79.08%	0.00	★★★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.
* For this indicator, a lower rate indicates better performance.
MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan's performance ranked at or above the 90th percentile for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, indicating children who turned 15 months old during the measurement year were getting at least six well-child visits with a PCP during their first 15 months of life most of the time. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-60] [**Quality**, **Timeliness**, and **Access**]

Strength #2: Upper Peninsula Health Plan's performance ranked between the 75th and 89th percentile for the *Breast Cancer Screening* measure, indicating women 50 to 74 years of age were being screened for breast cancer most of the time. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower healthcare costs.[3-61] [**Quality** and **Access**]

Strength #3: Upper Peninsula Health Plan's performance ranked at or above the 90th percentile for both of the *Hemoglobin A1c Control for Patients With Diabetes* measure indicators, *HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)*, indicating members with diabetes had controlled HbA1c levels most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-62] [**Quality** and **Access**]

Strength #4: Upper Peninsula Health Plan's performance ranked between the 75th and 89th percentile for the *Eye Exam for Patients With Diabetes* measure indicator, indicating members with diabetes had an eye exam to screen or monitor for diabetic retinal disease most of the time. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life.[3-63] [**Quality** and **Access**]

Strength #5: Upper Peninsula Health Plan's performance ranked at or above the 90th percentile for the *Blood Pressure Control for Patients With Diabetes* measure indicator, indicating members with diabetes had controlled blood pressure most of the time. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.[3-64] [**Quality** and **Access**]

Strength #6: Upper Peninsula Health Plan's performance ranked between the 75th and 89th percentile for the *Controlling High Blood Pressure* measure, indicating that members with a

[3-60] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.
[3-61] National Committee for Quality Assurance. Breast Cancer Screening (BCS, BCS-E). Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Mar 7, 2024.
[3-62] National Committee for Quality Assurance. Comprehensive Diabetes Care (CDC). Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Mar 7, 2024.
[3-63] Ibid.
[3-64] Ibid.

diagnosis of hypertension had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-65] [**Quality** and **Access**]

Strength #7: Upper Peninsula Health Plan's performance ranked at or above the 90th percentile for the *Controlling High Blood Pressure* measure, indicating members with a diagnosis of hypertension had controlled blood pressure most of the time. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-66] [**Quality** and **Access**]

Strength #8: Upper Peninsula Health Plan demonstrated overall strength in its HEDIS data reporting, as **Upper Peninsula Health Plan** was fully compliant with all seven IS standards and all performance measure rates were determined to be *Reportable*. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan's performance for all *Chlamydia Screening in Women* measure indicators ranked below the 25th percentile, indicating that women identified as sexually active were not always receiving at least one test for chlamydia during the measurement year. Screening is important, as approximately 75 percent of chlamydia infections in women are asymptomatic.[3-67] [**Quality**]

Why the weakness exists: The rates for all *Chlamydia Screening in Women* measure indicators ranked below the 25th percentile, suggesting barriers exist for some women identified as sexually active to receive testing for chlamydia.

Recommendation: While **Upper Peninsula Health Plan** noted several interventions currently in place to target improvement, such as including the measure in the 2023 HEDIS Value-Based Payment Alternative Payment Model and distributing educational letters to members ages 16 to 24 years on the importance of chlamydia screenings, performance for the *Chlamydia Screening in Women* measure indicators remains low. Therefore, HSAG recommends that **Upper Peninsula Health Plan** continue its efforts to improve performance for the *Chlamydia Screening in Women* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #2: Upper Peninsula Health Plan's performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17*, *Ages 18 to 21 Years*, and *Total* measure indicators ranked between the 25th and 49th percentile, indicating some children ages 3 to 21 years were not always receiving one or more well-care visit during the measurement year. Well-care visits provide an opportunity for

3-65 National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Mar 7, 2024.
3-66 Ibid.
3-67 National Committee for Quality Assurance. Chlamydia Screening in Women (CHL). Available at: https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/. Accessed on: Mar 7, 2024.

providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-68] [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The rate for the *Child and Adolescent Well-Care Visits—Ages 12 to 17*, *Ages 18 to 21 Years*, and *Total* measure indicators ranked between the 25th and 49th percentile, suggesting barriers exist for some children to receive timely well-care visits.

Recommendation: While **Upper Peninsula Health Plan** noted several interventions currently in place to target improvement, such as assisting members ages 18 to 21 years with establishing a new PCP, providing member education on the importance of well-care visits, and mailing a Transition to Adulthood care letter for members turning 18 years old, performance remains low for the *Child and Adolescent Well-Care Visits—Ages 12 to 17*, *Ages 18 to 21 Years*, and *Total* measure indicators. Therefore, HSAG recommends that **Upper Peninsula Health Plan** continue its efforts to improve performance for the *Child and Adolescent Well-Care Visits* measure. Initiatives should be monitored and expanded upon as additional contributing factors are identified.

Weakness #3: Upper Peninsula Health Plan's performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* measure indicator ranked between the 25th and 49th percentile, indicating that some members ages 75 to 85 years with a diagnosis of diabetes did not receive kidney health evaluations. Approximately 1 in 3 adults with diabetes has chronic kidney disease.[3-69] [**Quality** and **Access**]

Why the weakness exists: The rate for the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* measure indicator ranked between the 25th and 49th percentile, suggesting that barriers exist for members ages 75 to 85 years with diabetes to receive kidney health evaluations.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** conduct a root cause analysis or focused study to identify potential provider barriers, such as challenges in standardizing the inclusion of needed lab testing in treatment or appointment availability and to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of root causes, **Upper Peninsula Health Plan** should then implement appropriate member- and provider-focused interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.

[3-68] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits (W30, WCV). Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Mar 7, 2024.

[3-69] Centers for Disease Control and Prevention. Diabetes and Chronic Kidney Disease. Available at: https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html. Accessed on: Mar 7, 2024.

Compliance Review

Performance Results

Table 3-112 presents the total number of criteria for each standard that received a score of *Met, Satisfied*, or *Not Met*. Table 3-112 also presents **Upper Peninsula Health Plan**'s overall compliance score for each standard, the total compliance score across all standards, and their comparison to statewide averages. For elements scored as *Not Met*, **Upper Peninsula Health Plan** was subject to a corrective action review process outlined in Appendix A.

Table 3-112—Compliance Review Results for UPP

Standard		Number of Scores			Compliance Scores	
		Met	*Satisfied*[1]	*Not Met*	UPP[2]	Statewide[3]
1	Administrative	5	0	0	100%	100%
2	Providers	20	0	3	87%	94.7%
3	Members	28	0	1	97%	97.7%
4	Quality	22	0	0	100%	99.5%
5	MIS/Financial	39	1	0	98%	96.1%
6	OIG/Program Integrity	33	0	2	94%	90.2%
Overall		**147**	**1**	**6**	**95%**	**95.5%**

Indicates the standard scored below the statewide rate.

Indicates the standard had a score of 100 percent.

[1] A score of *Satisfied* was only allowable for select elements under the MIS/Financial standard.

[2] MDHHS calculated the total compliance score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard.

[3] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Additionally, to supplement the compliance review activity, MDHHS conducted staff interviews, referred to as focus studies, in the following three areas: CSHCS, Operations, and Quality. While the results of the focus studies are not incorporated into the scoring of the compliance review, **Upper Peninsula Health Plan** met MDHHS' expectations for participation in the studies.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan achieved full compliance in the Administrative standard, demonstrating that the MHP had an adequate administrative structure, including an organizational chart, administrative positions, governing body, participation in administrative meetings, and data privacy and oversight. [**Quality**]

Strength #3: Upper Peninsula Health Plan achieved full compliance in the Quality standard, demonstrating the MHP had an adequate quality program, which included, but was not limited to, CPGs; QIP description, work plan, and evaluation; UM program; program policies and procedures; HEDIS activities; PIPs; accreditation; addressing health disparities; and dental health quality. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: While **Upper Peninsula Health Plan** demonstrated moderate performance overall (i.e., 80 percent or higher but less than 90 percent) in the Providers standard, the MHP scored below the statewide average. The MHP received a *Not Met* score for elements *2.17 – Provider Site Performance Standards and Thresholds, 2.21 – Secret Shopper Calls – PCP Secret Shopper Calls,* and *2.22 Non-Emergency Medical Transportation (NEMT)*. [**Quality** and **Access**]

Why the weakness exists: Element *2.17 – Provider Site Performance Standards and Thresholds*, which was a deemable standard, was scored *Not Met* by NCQA; however, the specifics of the deficiency are unknown to HSAG. Additionally, the secret shopper survey identified that four out of the 12 providers contacted did not confirm they were accepting new patients as indicated in the provider online directory, and four out of the 12 providers contacted did not confirm that they were accepting the Medicaid MHP as indicated in the provider online directory. Further, as part of the NEMT driver qualifications review, the MHP did not conduct sex offender registry checks as required. The MHP noted that its current process is to use iChat to search for sex offender registries; however, MDHHS indicated that iChat only identifies registered sex offenders in the State of Michigan, and the requirement is for all states.

Recommendation: Upper Peninsula Health Plan was required to submit a CAP to address element 2.22, which was approved by MDHHS. However, for element 2.17, **Upper Peninsula Health Plan** entered a CAP with NCQA; therefore, MDHHS did not require any further action. Additionally, at the time MDHHS provided HSAG with the compliance review findings, MDHHS had not yet determined if a CAP will be required to address element 2.21. As such, HSAG recommends that **Upper Peninsula Health Plan** continue to implement action plans and monitoring processes to ensure that the MHP sets appropriate standards and thresholds for provider site reviews, ensures all contracted providers are aware of their contracts and notify the MHP when they are no longer accepting new patients, and checks all states' sex offender registries for NEMT driver qualifications.

Weakness #2: While **Upper Peninsula Health Plan** demonstrated high performance overall (i.e., 90 percent or higher but less than 100 percent) in the Members standard, the MHP scored below the

statewide average. The MHP received a *Not Met* score for element *3.20 – Maintaining and Sharing Member Health Records*. [**Quality** and **Access**]

Why the weakness exists: Element *3.20 – Maintaining and Sharing Member Health Records*, which was a deemable standard, was scored *Not Met* by NCQA; however, the specifics of the deficiency are unknown to HSAG.

Recommendation: **Upper Peninsula Health Plan** entered a CAP with NCQA; therefore, MDHHS did not require any further action. As such, HSAG recommends that **Upper Peninsula Health Plan** continue to implement action plans developed as part of the NCQA CAP process, review the results of the action plans regularly, and update its action plans as necessary.

Network Adequacy Validation

Performance Results

HSAG's reviewers evaluated a sample of 109 cases by comparing provider data that **Upper Peninsula Health Plan** submitted to HSAG against **Upper Peninsula Health Plan**'s online provider directory. The sample included 82 PCPs, 13 pediatric providers, and 14 OB/GYN providers (Table 3-113). Among this sample, the provider's name and location listed in the submitted provider data were found in the online provider directory for 93.6 percent (n=102) of the reviews. The sampled providers were not found in the online provider directory in 6.4 percent (n=7) of the reviewed cases.

Table 3-113—Summary of Providers Present in the Directory by Provider Category

		Providers Found in Directory		Providers Not Found in Directory	
Provider Category	Number of Sampled Providers	Count	%	Count	%
PCPs	82	77	93.9%	5	6.1%
Pediatric Providers	13	11	84.6%	2	15.4%
OB/GYN Providers	14	14	100%	0	0.0%
UPP Total	**109**	**102**	**93.6%**	**7**	**6.4%**

Table 3-114 displays the total number of cases and the percentage of cases with matched data values, overall and by provider category, for indicators that were reviewed for matching between **Upper Peninsula Health Plan**'s provider data submission to HSAG and **Upper Peninsula Health Plan**'s online provider directory.

Table 3-114—Provider Demographic Indicators Matching Online Provider Directory

	PCPs		Pediatric Providers		OB/GYN Providers		All Provider Categories	
Indicator	Count	%	Count	%	Count	%	Count	%
Provider's Name	77	100%	11	100%	14	100%	102	100%
Provider Street Address	76	98.7%	11	100%	14	100%	101	99.0%
Provider Suite Number	77	100%	11	100%	14	100%	102	100%
Provider City	76	98.7%	11	100%	14	100%	101	99.0%
Provider State	77	100%	11	100%	14	100%	102	100%
Provider ZIP Code	76	98.7%	11	100%	14	100%	101	99.0%
Provider Telephone Number	74	96.1%	11	100%	14	100%	99	97.1%
Provider Type/Specialty	76	98.7%	10	90.9%	14	100%	100	98.0%
Provider Accepting New Patients	76	98.7%	11	100%	14	100%	101	99.0%
Provider Gender	77	100%	11	100%	14	100%	102	100%
Provider Primary Language*	77	100%	11	100%	14	100%	102	100%
Non-English Language Speaking Provider (including American Sign Language)*	62	80.5%	11	100%	2	14.3%	75	73.5%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 97 sampled provider locations (i.e., "cases") for **Upper Peninsula Health Plan**, with an overall response rate of 91.8 percent (n=89). Table 3-115 summarizes the secret shopper survey results for **Upper Peninsula Health Plan**.

Table 3-115—Summary of UPP Secret Shopper Survey Results

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
PCPs	73	69	94.5%	65	94.2%	63	91.3%	62	89.9%	53	76.8%
Pediatric Providers	10	8	80.0%	8	100%	8	100%	8	100%	8	100%

		Response Rate		Confirmed Provider		Correct Location		Offering Specialty		Accepting Insurance	
Provider Category	Total Cases	Cases Reached	Response Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)	Count	Rate (%)
OB/GYN Providers	14	12	85.7%	11	91.7%	11	91.7%	10	83.3%	8	66.7%
UPP Total	**97**	**89**	**91.8%**	**84**	**94.4%**	**82**	**92.1%**	**80**	**89.9%**	**69**	**77.5%**

Table 3-116 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics for **Upper Peninsula Health Plan**, by provider category. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 3-116—Appointment Availability Results

			Cases Offered an Appointment			Appointment Wait Time (Days)				
Provider Category	Total Survey Cases	Cases Accepting New Patients	Count	Rate Among All Surveyed Cases[1] (%)	Rate Among Cases Accepting New Patients[2] (%)	Min	Max	Average	Median	Percentage of Cases Within Standard[3]
PCPs	73	52	34	46.6%	65.4%	0	138	27	21	61.8%
Pediatric Providers	10	8	7	70.0%	87.5%	5	45	18	13	85.7%
OB/GYN Providers	14	8	4	28.6%	50.0%	4	12	7	6	75.0%
UPP Total	**97**	**68**	**45**	**46.4%**	**66.2%**	**0**	**138**	**24**	**13**	**66.7%**

[1] The denominator includes all surveyed cases included in the sample.
[2] The denominator includes cases responding to the survey that accept the insurance and new patients.
[3] The denominator includes cases offered an appointment. The MDHHS appointment timeliness standards are 30 business days for routine care appointments and seven business days for prenatal care appointments.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Of the 93.6 percent of providers that reviewers located in **Upper Peninsula Health Plan**'s online provider directory, 11 of 12 indicators had match rates above 95 percent. [**Quality** and **Access**]

Strength #2: Overall, 91.8 percent of **Upper Peninsula Health Plan**'s locations could be reached. [**Quality** and **Access**]

Strength #3: Of the locations reached, 94.4 percent confirmed affiliation with the sampled provider. Additionally, 92.1 percent confirmed accuracy of the sampled address and 89.9 percent confirmed the requested services were offered. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Of the locations reached, only 77.5 percent confirmed the requested insurance was accepted.

Why the weakness exists: **Upper Peninsula Health Plan**'s provider data included invalid insurance information.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (i.e., records with incorrect insurance information) to address the provider data deficiencies.

Weakness #2: Of the cases responding to the survey and accepting the insurance and new patients, only 66.2 percent of locations offered an appointment date. However, pediatric providers had an appointment availability rate of 87.5 percent, PCPs had an appointment availability rate of 65.4 percent, while OB/GYN provider locations had an appointment availability rate of 50.0 percent. [**Access**]

Why the weakness exists: For new **Upper Peninsula Health Plan** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Considerations included pre-registration as well as requiring additional personal information, a Medicaid ID, or a medical record review. While callers did not specifically ask about limitations to appointment availability, these considerations may represent common processes among providers' offices to facilitate practice operations.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Upper Peninsula Health Plan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

Encounter Data Validation

Performance Results

Representatives from **Upper Peninsula Health Plan** completed an MDHHS-approved questionnaire supplied by HSAG. HSAG identified follow-up questions based on **Upper Peninsula Health Plan**'s original questionnaire responses, and **Upper Peninsula Health Plan** responded to these specific questions. To support its questionnaire responses, **Upper Peninsula Health Plan** submitted a wide range of documents with varying formats and levels of detail. The IS review gathered input and self-reported qualitative insights from **Upper Peninsula Health Plan** regarding its encounter data processes.

The administrative profile analyzes MDHHS' encounter data for completeness, timeliness, and accuracy by evaluating the data across multiple metrics and using supplemental data (e.g., member enrollment and demographic data, and provider data). Results of these analyses can help indicate the reliability of MDHHS' data to be used in subsequent analyses, such as rate setting and performance measure calculations.

Table 3-117 provides a list of the multifaceted analysis conducted for each of the EDV study components (i.e., IS review and administrative profile). The table contains key findings based on the overall understanding of the encounter data processes, as well as findings that contributed to the overall completeness, timeliness, and accuracy of MDHHS' encounter data.

Table 3-117—EDV Results for UPP

Analysis	Key Findings
IS Review	
Encounter Data Sources and Systems	• **Upper Peninsula Health Plan** utilized Python Parser as its primary software for claim adjudication and encounter preparation. • **Upper Peninsula Health Plan** had processes in place to detect and identify duplicate claims. **Upper Peninsula Health Plan** specified scenarios in which claims were not submitted, including denials due to primary insurance, member ineligibility, inappropriate providers, or those failing CHAMPS editing. When adjustments were necessary, the claim frequency code "7" was used to indicate an adjusted encounter. • **Upper Peninsula Health Plan** and its subcontractors were responsible for collecting and maintaining provider information. Additionally, **Upper Peninsula Health Plan** managed enrollment data received from MDHHS through 834 files, providing daily Medicaid enrollment updates to the MHPs for integration into their claim processing systems. **Upper Peninsula Health Plan** ensured that subcontractors also received and incorporated these enrollment details into their respective claim systems.

Analysis	Key Findings
Payment Structures	• **Upper Peninsula Health Plan** utilized various claim payment methods for different encounter types. For inpatient encounters, it employed percent billed, line-by-line, per diem, and DRG methods. For outpatient encounters, the methods included line-by-line, per diem, and capitation. Pharmacy encounters were processed using the negotiated (flat) rate and ingredient cost methods as well as an unspecified method. • In general, **Upper Peninsula Health Plan** processed claims with TPL based on the collected insurance coverage information. When a claim suggests the existence of additional primary insurance for a member, the MHP's system cross-checks this information. If details of the primary insurance are found, the system coordinates it with the payment data to calculate the owed amount. In case additional insurance information is provided later, the claim undergoes a reprocessing, with payment adjustments made based on the new insurance details.
Encounter Data Quality Monitoring	• **Upper Peninsula Health Plan** and/or its subcontractors performed various data quality checks on the encounter data collected. These checks included, but were not limited to, analyzing claim volume by submission month (for pharmacy encounters), assessing field-level completeness and validity (for both dental and pharmacy encounters), evaluating timeliness (for pharmacy encounters), and ensuring alignment between payment fields in claims and financial reports (for dental encounters). • For encounters collected by **Upper Peninsula Health Plan**, it assessed field-level completeness and accuracy and verified the alignment of payment fields in claims with the financial reports.
Administrative Profile	
Encounter Data Completeness	• **Upper Peninsula Health Plan** displayed consistent encounter volume for professional, institutional, dental, and pharmacy encounters throughout the measurement year. • **Upper Peninsula Health Plan** had a low volume of duplicate encounters, with less than 0.1 percent of professional encounters, less than 0.1 percent of institutional encounters, 0.3 percent of dental encounters, and 0.0 percent of pharmacy encounters identified as duplicative.
Encounter Data Timeliness	• **Upper Peninsula Health Plan** demonstrated timely submission of professional, institutional, dental, and pharmacy encounters. Within 30 days, **Upper Peninsula Health Plan** submitted 99.7 percent of professional encounters and 99.3

Analysis	Key Findings
	percent of institutional encounters to MDHHS after the payment date. • Within 60 days, **Upper Peninsula Health Plan** submitted 99.9 percent of dental encounters, and within 30 days, **Upper Peninsula Health Plan** submitted 99.2 percent of pharmacy encounters to MDHHS after the payment date.
Field-Level Completeness and Accuracy	• All data elements in **Upper Peninsula Health Plan**'s submitted data had high rates of population and validity.
Encounter Referential Integrity	• Of all identified member IDs in **Upper Peninsula Health Plan**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the enrollment data. • Of all identified member IDs in **Upper Peninsula Health Plan**'s submitted pharmacy data, 99.9 percent were identified in the enrollment data. • Of all identified provider NPIs in **Upper Peninsula Health Plan**'s submitted professional, institutional, and dental encounter data, greater than 99.9 percent were identified in the provider data. • Of all identified provider NPIs in **Upper Peninsula Health Plan**'s submitted pharmacy encounter data, 87.9 percent were identified in the provider data.
Encounter Data Logic	• No major concerns were noted for **Upper Peninsula Health Plan**.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan demonstrated its capability to collect, process, and transmit encounter data to MDHHS. The MHP has also established data review and correction processes that efficiently address quality concerns identified by MDHHS. [**Quality**]

Strength #2: Upper Peninsula Health Plan submitted professional, institutional, dental, and pharmacy encounters in a timely manner from the payment date, with about 99 percent of all encounters submitted within 60 days of the payment date. [**Quality** and **Timeliness**]

Strength #3: Across all categories of service, key data elements for **Upper Peninsula Health Plan** were populated at high rates and generally greater than 95 percent valid. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan did not indicate timeliness quality checks performed for claims/encounters stored in its data warehouses. [**Quality**]

Why the weakness exists: Only field-level accuracy, completeness, and reconciliation with financial reports were listed as being conducted, and no check for timeliness was mentioned.

Recommendation: Upper Peninsula Health Plan should build a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness for encounters collected by **Upper Peninsula Health Plan**.

Weakness #2: Although greater than 99.9 percent of provider NPIs identified in the medical/dental data were identified in the provider data, approximately 88 percent of the provider NPIs identified in the pharmacy data could be identified in the provider data. [**Quality**]

Why the weakness exists: Linking datasets to each other to pull in additional information (i.e., provider type, provider specialty, or provider address) may be important in subsequent analyses, such as performance measure calculations and network adequacy activities.

Recommendation: Upper Peninsula Health Plan should work with MDHHS to ensure both entities have an accurate and complete database of contracted providers.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results—Adult and Child Medicaid

Table 3-118 presents **Upper Peninsula Health Plan**'s 2022 and 2023 adult and child Medicaid CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-118—Summary of Adult and Child Medicaid CAHPS Top-Box Scores for UPP

	2022 Adult Medicaid	2023 Adult Medicaid	2022 Child Medicaid	2023 Child Medicaid
Global Ratings				
Rating of Health Plan	71.12%	64.44% ▼	67.51%	70.43%
Rating of All Health Care	56.13%	52.81%	70.20%	60.93% ▼↓
Rating of Personal Doctor	71.87%	67.48%	76.68%	73.09%
Rating of Specialist Seen Most Often	62.84%	64.61%	75.00%+	63.77%+
Composite Measures				
Getting Needed Care	84.35%	83.19%	87.37%	89.89% ↑
Getting Care Quickly	87.09%	85.88% ↑	94.19%	92.67% ↑
How Well Doctors Communicate	95.42%	95.44% ↑	97.08%	98.48% ↑
Customer Service	94.81%	92.77% ↑	90.61%+	97.30%+ ↑
Individual Item Measure				
Coordination of Care	83.72%	87.65%	84.69%+	91.00% ↑
Medical Assistance With Smoking and Tobacco Use Cessation Items*				
Advising Smokers and Tobacco Users to Quit	76.40%	73.44%	—	—
Discussing Cessation Medications	58.87%	53.18%	—	—
Discussing Cessation Strategies	52.69%	48.10%	—	—

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.

↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations—Adult and Child Medicaid

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for three measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. [**Quality** and **Timeliness**]

Strength #2: Upper Peninsula Health Plan's 2023 top-box scores were statistically significantly higher than the 2022 NCQA child Medicaid national averages for five measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan's 2023 top-box score was statistically significantly lower than the 2022 adult Medicaid top-box score for one measure, *Rating of Health Plan*. [**Quality**]

Why the weakness exists: When compared to national benchmarks, the results indicate **Upper Peninsula Health Plan**'s members are reporting more negative experiences with their health plan. The MHP reported that its CAHPS report is reviewed by the CAHPS Taskforce to identify low-performing measures, rate trends, and to identify the questions that are the key drivers for impacting the rate. This information is used to develop initiatives to improve the rate of each key driver question. However, HSAG is unable to identify the MHP-specific barriers or other factors impacting drivers for these measures based on the information provided through this EQR.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** continue to explore the drivers of this lower experience score and develop initiatives designed to improve quality of care.

Weakness #2: Upper Peninsula Health Plan's 2023 top-box score was statistically significantly lower than the 2022 child Medicaid national average and 2022 child Medicaid top-box score for one measure, *Rating of All Health Care*. [**Quality**]

Why the weakness exists: When compared to national benchmarks and the previous year's top-box scores, parents/caretakers of child members enrolled in **Upper Peninsula Health Plan** had less positive overall experiences with their child's healthcare. The MHP reported that its CAHPS report is reviewed by the CAHPS Taskforce to identify low-performing measures, rate trends, and to identify the questions that are the key drivers for impacting the rate. This information is used to

develop initiatives to improve the rate of each key driver question. However, HSAG is unable to identify the MHP-specific barriers or other factors impacting drivers for these measures based on the information provided through this EQR.

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** continue to explore the drivers of this lower experience score and develop initiatives designed to improve quality of care.

Performance Results—CSHCS

Table 3-119 presents **Upper Peninsula Health Plan**'s 2022 and 2023 CSHCS CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-119—Summary of CSHCS CAHPS Survey Top-Box Scores for UPP

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	67.37%+	73.33%
Rating of Health Care	73.68%+	69.16% NA
Rating of Specialist Seen Most Often	83.58%+	77.42%+
Rating of CMDS Clinic	88.24%+	85.71%+ NA
Composite Measures		
Customer Service	91.18%+	92.50%+ NA
How Well Doctors Communicate	98.01%+	98.77%+ NA
Access to Specialized Services	70.11%+	75.47%+ NA
Transportation	97.22%+	92.37%+ NA
Individual Item Measures		
Access to Prescription Medicines	90.41%+	96.10%+ ↑
CMDS Clinics	94.12%+	93.33%+ NA
Local Health Department Services	81.82%+	89.74%+ NA
Not Felt Treated Unfairly: Race and Ethnicity	96.05%+	100.00%+ NA
Not Felt Treated Unfairly: Health Insurance Type	97.37%+	95.06%+ NA

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating the results.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.
NA indicates a national average is not available for the measure.

Strengths, Weaknesses, and Recommendations—CSHCS

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, *Access to Prescription Medicines*. [**Quality and Access**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA child Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** monitor the measures to ensure significant decreases in scores over time do not occur.

Performance Results—HMP

Table 3-120 presents **Upper Peninsula Health Plan**'s 2022 and 2023 HMP CAHPS top-box scores. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2022 national average. Triangles (▲ or ▼) indicate 2023 scores were statistically significantly higher or lower than the 2022 scores.

Table 3-120—Summary of HMP CAHPS Top-Box Scores for UPP

	2022 Top-Box Score	2023 Top-Box Score
Global Ratings		
Rating of Health Plan	67.17%	66.78%
Rating of All Health Care	51.56%	55.49%
Rating of Personal Doctor	65.63%	72.92%
Rating of Specialist Seen Most Often	72.41%	63.55%
Composite Measures		
Getting Needed Care	84.87%	87.17% ↑
Getting Care Quickly	86.04%	83.24%

	2022 Top-Box Score	2023 Top-Box Score
How Well Doctors Communicate	95.35%	94.59%
Customer Service	90.00%+	84.75%+
Individual Item Measure		
Coordination of Care	86.05%+	84.62%+
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	69.71%	73.06%
Discussing Cessation Medications	50.41%	52.70%
Discussing Cessation Strategies	45.00%	48.18%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
▲ Indicates the 2023 score is statistically significantly higher than the 2022 score.
▼ Indicates the 2023 score is statistically significantly lower than the 2022 score.
No triangles (▲ or ▼) indicate the 2023 score was not statistically significantly higher or lower than the 2022 score.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2022 national average.

Strengths, Weaknesses, and Recommendations—HMP

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS activity have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Upper Peninsula Health Plan's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Getting Needed Care*. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: Upper Peninsula Health Plan's 2023 top-box scores were not statistically significantly lower than the 2022 NCQA adult Medicaid national averages or the 2022 top-box scores for any measure; therefore, no substantial weaknesses were identified.

Why the weakness exists: NA

Recommendation: HSAG recommends that **Upper Peninsula Health Plan** monitor the measures to ensure significant decreases in scores over time do not occur.

Quality Rating

The 2023 Michigan Consumer Guide was designed to compare MHP-to-MHP performance using HEDIS and CAHPS measure indicators. As such, MHP-specific results are not included in this section. Refer to the Quality Rating activity in Section 5—Medicaid Health Plan Comparative Information to review the 2023 Michigan Consumer Guide, which is inclusive of **Upper Peninsula Health Plan**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **Upper Peninsula Health Plan**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Upper Peninsula Health Plan** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Upper Peninsula Health Plan**'s overall performance contributed to the CHCP's progress in achieving the CQS goals and objectives. Table 3-121 displays each applicable performance area and the overall performance impact related to the quality, timeliness, and accessibility of healthcare services provided to **Upper Peninsula Health Plan**'s Medicaid members.

Table 3-121—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Addressing Health Inequity	**Quality**, **Timeliness**, and **Access—Upper Peninsula Health Plan** continued its MDHHS-mandated PIP focused on reducing the disparity for its Black member population in adult ambulatory and preventive access to care. The goal of the PIP was that there will no longer be a statistically significant rate difference between the two subgroups, and the disparate subgroup (Black members) will demonstrate a significant increase over the baseline rate without a decline in performance for the comparison subgroup (White members), or achieve clinically or programmatically significant improvement as a result of an intervention. Among other interventions, **Upper Peninsula Health Plan** implemented member outreach to the target population to perform a survey to identify barriers to completing care and education and coordination of care. The intervention contributed to a slight improvement in the rate of the Black population receiving an annual ambulatory or preventive visit, demonstrating an increase of 1.1 percentage points. The CDC recommends that all patients obtain regular checkups, including physical exams, screening tests, and vaccines to reduce the likelihood of getting a chronic disease. Also, according to the Mayo Clinic News Network, African-American patients are at a higher risk of developing chronic conditions, such as heart disease, high blood pressure, obesity, diabetes, and stroke. Therefore, it is imperative that African-American members obtain a preventive care appointment on an annual basis to lower their chances of getting a chronic disease. However, the comparison population of **Upper Peninsula Health Plan**'s PIP, White members, demonstrated a statistically significant decline of 1.8

Performance Area	Overall Performance Impact
	percentage points. Opportunities for improving adults' access to preventive care is also supported by the results of the HEDIS audit documented within the 2023 HEDIS Aggregate Report for Michigan Medicaid located in Appendix B. The rate for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years* measure decreased by 1.66 percentage points compared to the prior year, which demonstrated a statistically significant decline, and the rate ranked between the 50th and 74th Medicaid Quality Compass percentile. As the CDC recommends that all patients obtain a regular preventive care appointment, **Upper Peninsula Health Plan** should explore what may be decreasing this performance and consider if its Black members may be experiencing additional barriers or if other disparities exist within the data (i.e., geographic location) that should be targeted for improvement. **Upper Peninsula Health Plan** met MDHHS' expectations for addressing health disparities through population health management as demonstrated by a 100 percent compliance score for the Quality standard; and specifically, a *Met* score for element *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*, demonstrating that it had adequate policies and procedures for providing population health management services. **Upper Peninsula Health Plan** should continue to conduct data analysis through its quality program to identify and subsequently implement interventions to reduce disparities in healthcare. Further, the results of the NAV activity indicate that some of **Upper Peninsula Health Plan**'s members may be experiencing challenges scheduling appointments with PCPs due to incorrect insurance information. Lastly, of providers responding to the survey and accepting the insurance and new patients, only 65.4 percent of PCPs offered an appointment and only 61.8 percent of the PCPs who offered an appointment met MDHHS' appointment timeliness standard of 30 business days. **Upper Peninsula Health Plan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements to further ensure members are able to obtain timely access to preventive care.
Preventive Care	**Quality**, **Timeliness**, and **Access**—The results of the PMV activity confirmed opportunities for **Upper Peninsula Health Plan** to improve access to preventive care. Three of the four rates for the *Child and Adolescent Well-Care Visits* measure and all rates for the *Chlamydia Screening in Women* measure ranked either below the 25th Medicaid Quality Compass percentile or between the 25th and 49th percentile. Preventive care and screenings can monitor growth and development, reduce the chance of contracting a vaccine preventable condition, and lead to early detection of cancer. Additionally, the results of the NAV activity indicate that some of **Upper Peninsula Health Plan**'s members may be experiencing challenges

Performance Area	Overall Performance Impact
	scheduling appointments with PCPs or pediatric providers due to incorrect insurance information. Further, of providers responding to the survey and accepting the insurance and new patients, only 65.4 percent and 87.5 percent of PCPs and pediatric providers, respectively, offered an appointment; and of the providers who offered a routine appointment, only 61.8 percent of PCPs and 85.7 percent of pediatric providers offered the appointment timely (i.e., within MDHHS' appointment time frame of 30 business days). **Upper Peninsula Health Plan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members and to educate providers on appointment timeliness requirements. Further, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from its prior year or to the national average, the rates ranged from 67.48 percent to 73.09 percent. **Upper Peninsula Health Plan** should also consider these results when determining potential barriers for members accessing preventive care due to dissatisfaction with their PCP. However, **Upper Peninsula Health Plan** also demonstrated strengths related to preventive care as one rate for the *Well-Child Visits in the First 30 Months of Life* met the 90th Medicaid Quality Compass percentile and the other rate for this measure scored between the 50th and 74th percentile, and both rates for this measure demonstrated improvement over the prior year. Additionally, the *Cervical Cancer Screening* measure rate ranked between the 50th and 74th Medicaid Quality Compass percentile and demonstrated slight improvement from the prior year, and the *Breast Cancer Screening* measure rate scored between the 75th and 90th percentile and demonstrated slight improvement from the prior year. Screenings can lead to early treatment of cervical and breast cancers and reduce the occurrence of serious complications. Further, as demonstrated through the compliance review, **Upper Peninsula Health Plan** met MDHHS' expectations for monitoring appointment wait times for preventive services. Specifically, **Upper Peninsula Health Plan** received a *Met* score for element *2.10 Provider Wait Times* under the Providers standard, which included but was not limited to monitoring of the following metrics: *Routine Care is available within 30 Business Days of request*, *Routine Dental Care is within 21 Business Days of request*, and *Preventive Dental Services is within six weeks of request*.
Care for Chronic Conditions	**Quality**, **Timeliness**, and **Access—**Overall, **Upper Peninsula Health Plan** demonstrated mostly mixed results across the EQR activities as it pertains to chronic conditions. The PMV activity results confirmed that **Upper Peninsula Health Plan** met the 90th Medicaid Quality Compass percentile for both rates for the *Hemoglobin A1c Control for Patients With Diabetes* measure, the rate

Performance Area	Overall Performance Impact
	for the *Blood Pressure Control for Patients With Diabetes* measure, and the rate for the *Controlling High Blood Pressure* measure. Additionally, **Upper Peninsula Health Plan** ranked between the 75th and 90th Medicaid Quality Compass percentile for the *Eye Exam for Patients With Diabetes* measure and between the 50th and 74th percentile for three of the four rates for the *Kidney Health Evaluation for Patients With Diabetes* measure. These results indicate that many of **Upper Peninsula Health Plan**'s members were receiving care to manage their chronic conditions. Appropriate management of chronic conditions can reduce symptoms and the chance of serious complications and improve quality of life. Further, as demonstrated by a *Met* score for element *3.10 CSHCS PCP Requirements* under the Members standard of the compliance review, **Upper Peninsula Health Plan** met MDHHS' expectations for assignment of PCPs for children and youth with complex chronic conditions. However, the results of the NAV activity indicate that some of **Upper Peninsula Health Plan**'s members may be experiencing challenges in scheduling appointments with PCPs due to incorrect insurance information. Further, of providers responding to the survey and accepting the insurance and new patients, only 65.4 percent of PCPs offered an appointment and only 61.8 percent of the PCP offices that offered an appointment were within the MDHHS appointment timeliness standard of 30 business days. **Upper Peninsula Health Plan** should use the results of the NAV activity and internal monitoring mechanisms to improve the accuracy of provider information that is available to members, and to educate providers on appointment timeliness requirements. Further, while **Upper Peninsula Health Plan** generally performed well for the *Kidney Health Evaluation for Patients With Diabetes* measures, one rate, *Ages 75 to 85 Years*, ranked between the 25th and 49th Medicaid Quality Compass percentile and declined by 5.48 percentage points from the prior year. **Upper Peninsula Health Plan** should continue efforts in identifying interventions to mitigate barriers to care and ensure its members' chronic conditions are appropriately managed. Unmanaged chronic conditions lead to poor member outcomes and increased healthcare costs. Lastly, while the CAHPS measure, *Rating of Personal Doctor*, for the adult and child Medicaid and HMP populations did not demonstrate a statistically significant higher or lower score from the prior year or to the national average, the rates ranged from 67.48 percent to 73.09 percent. **Upper Peninsula Health Plan** should also consider these results when determining potential barriers for members accessing care for chronic conditions due to dissatisfaction with their PCP.

Performance Area	Overall Performance Impact
Health Information Systems and Technology	**Quality**, **Timeliness**, and **Access—Upper Peninsula Health Plan** demonstrated strengths of its health information systems and technology through the PMV, compliance, and EDV activities. The PMV findings confirmed that **Upper Peninsula Health Plan** was fully compliant with how it collected, stored, analyzed, and reported HEDIS data. All rates were *Reportable*, indicating that **Upper Peninsula Health Plan** followed the NCQA technical specifications for the calculation of HEDIS performance measures. Additionally, **Upper Peninsula Health Plan** scored above the statewide average for the MIS/Financial standard within the compliance review activity, with a score of 98 percent, indicating that it met MDHHS' expectations for most requirements pertaining to **Upper Peninsula Health Plan**'s MIS. Further, through the EDV activity, **Upper Peninsula Health Plan** demonstrated its capability to collect, process, and transmit encounter data to MDHHS; submit encounter data timely; and populate valid key data elements for all service categories. However, as **Upper Peninsula Health Plan** did not report that timeliness quality checks were conducted for claims and encounters stored in its data warehouses, it should consider building a comprehensive set of monitoring reports to evaluate encounter data accuracy, completeness, and timeliness for encounters collected by **Upper Peninsula Health Plan**. Additionally, as fewer pharmacy provider NPIs were identified in provider data than medical and dental provider NPIs, **Upper Peninsula Health Plan** should also collaborate with MDHHS to ensure both entities have an accurate and complete database of contracted providers. Lastly, as demonstrated through the compliance review findings, **Upper Peninsula Health Plan** was not fully compliant for one reporting month with the *Encounter record transmissions must meet or exceed a 95% acceptance rate for encounters loaded into CHAMPS* metrics under compliance review element *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS*. Therefore, **Upper Peninsula Health Plan** should continue to implement action plans and monitoring processes to ensure all encounter performance standards are consistently met.

4. Follow-Up on Prior External Quality Review Recommendations for Medicaid Health Plans

From the findings of each MHP's performance for the SFY 2022 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the CHCP. The recommendations provided to each MHP for the EQR activities in the *State Fiscal Year 2022 External Quality Review Technical Report for Medicaid Health Plans* are summarized in Table 4-1 through Table 4-9. The MHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 4-1 through Table 4-9.

Additional performance measures and performance measure results are included in Appendix B. 2023 HEDIS Aggregate Report for Michigan Medicaid. HSAG used this supplemental information to assess the degree to which each MHP addressed the prior year's recommendations.

Aetna Better Health of Michigan

Table 4-1—Prior Year Recommendations and Responses for AET

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Aetna Better Health of Michigan** did not achieve a *Met* score for all requirements in the Design stage of the project, indicating gaps in the MHP's documentation, specifically within the analysis and reporting of plan-specific data used to select the PIP topic, which resulted in the overall validation rating of *Partially Met*. While **Aetna Better Health of Michigan** identified through data analysis a disparity between its rural and urban populations for the PIP topic, the MHP did not report its statistical testing between the two subgroups to support selection of the PIP topic. HSAG recommends that **Aetna Better Health of Michigan** conduct statistical testing between the two PIP populations to establish an existing disparity between the two subgroups.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Addressing Disparities in Timeliness of Prenatal Care in Rural Communities NEW INTERVENTIONS • *Mae* is a doula program offered whose mission is to provide a culturally sensitive, maternity support solution with content and services geared specifically towards African American, expectant mothers in

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
Detroit, Michigan. The solution offers complementary services for prenatal and postnatal care, member education, peer/social support, in-person doulas, health tracking, and curated content. In addition, *Mae* identifies potential doulas in the plan-provided target regions, meets with these doulas and checks them against any state requirements or plan-specific requirements. • Aetna Better Health of Michigan (ABHMI) partners with *GA Foods* to offer complete nutritional solution to support pregnant women and new mothers who face challenges related to social determinates of health. • ABHMI collaborates with *Vheda Health* to provide remote patient monitoring (RPM) services. This intervention is in response to the findings found through the literature review and focus group. African American women expressed concerns that going to the doctor is a significant burden and they are less likely to comply with appointments and medications. RPM is not to take the place of a doctor's visit but to enhance the member's access to their provider without the member leaving her home. • ABHMI partners with *Pyx Health,* a mobile app solution that reduces loneliness and social isolation. It connects the most vulnerable members to critical and timely interventions, as well as addresses social determinants of health (SDoH) that can help with postpartum women needing extra support. CONTINUING • ABHMI covers centering pregnancy programs that provide prenatal care in a group setting to birthing members (10, 90-minute to two-hour prenatal visits with provider). • Monthly statistical testing outcomes for timeliness of prenatal care rural to urban are regularly evaluated. • A $50 incentive for timely completion of prenatal care visit (first trimester or within 42 days of enrollment on the plan) is provided by ABHMI. • A $50 incentive for timely completion of postpartum care visit (7-84 days after delivery of baby) is provided by ABHMI. • Free transportation to and from appointments is provided by ABHMI through the vendor Access2Care. • ABHMI facilitates members' connection to Maternal Health Infant Programs (MIHP) in the member's community. • ABHMI regularly assesses social determinants of health (SDoH) and their impact on Postpartum Care (PPC) rate through Case Management (CM) Health Care Equity data, monthly FindHelp reporting/connections, community health needs assessment and International Classification of Disease-10-Z (ICD-10 Z) coding monitoring/analysis. • Consistent CM is involved with any pregnant member with special consideration of those identified as higher risk. • Neighborhood Service Organization (NSO) is a community program offered that supports the care management team by providing additional face-to-face case management services in the member's home throughout the member's pregnancy journey. These care management services include assessments of SDoH, support for accessing services, and referrals to support opportunities. Members have in-home access to care with a nurse practitioner who will complete prenatal and postpartum visits as well as provide health and wellness education to increase health literacy. • ABHMI's dental vendor DentaQuest offers a program called Smiling Stork that provides targeted outreach to pregnant members to provide education on dental benefits, importance of oral health for the

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
member and their children as well as encouragement to see their dental provider within the first 90 days of initial outreach. • The contract with a health intelligence platform is maintained to offer pregnant members solutions to improve their quality of care and engagement in the healthcare system. This health intelligence platform will allow pregnant women access to the Baby Smart coaching program that supports appointment and transportation scheduling, pregnancy and parenting education, pregnancy monitoring and postpartum health goals, quick connections to any needed critical resources for social risks/SDoH as well as virtual doula pairing for high-risk pregnant women. The health intelligence platform solution is leveraged for multimodal communication methods including text, outreach calls, mailings, dashboard access, pregnancy "pals", birthing support and advocacy as well as educational resources. • ABHMI utilizes member education materials by emphasizing importance of early prenatal care. Mailers are sent to all female members aged 18-40 years old. The inclusion of a prenatal care text and interactive voice response (PMR) campaign for all confirmed pregnant members on importance of prenatal care is also included. • Members are regularly educated on appropriate timeline to seek obstetrician (OB), gynecologist (GYN), or primary care provider (PCP) visits and are discouraged from using emergency department (ED) and Urgent Care visits as a last resort. • ABHMI consistently leverages multimodal communications using a combination of IVR, text, email, and mailers to send educational messages to engage members in completing prenatal/postpartum care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Timeliness of Prenatal Care (TOPC) and Postpartum Care (PPC) measures increased year over year (YOY) because of initiatives implemented. A 1.21 percentage point rate lift was seen YOY in the TOPC measure and a 4.63 percentage point rate lift was seen YOY in the PPC measure. o Prenatal and Postpartum Care YOY 3.16% increase ▪ PN [prenatal] 68.86% PP [postpartum] 54.01% MY2020 ▪ PN 70.07% PP 58.64% MY2021 ▪ PN 64.48% PP 61.80% MY2022
c. Identify any barriers to implementing initiatives: • There has been a decline in reachable members (i.e., members that do not answer their phones or do not have working phone numbers). It is a significant challenge to determine what barriers exist without directly speaking to members that are non-compliant for services. Facilitating community mapping exercises may aid better understanding of the barriers that exist for women residing in rural communities. • There are few innovative, technological interventions to impact prenatal care rates. Leveraging mailings, text campaigns, incentives, and live outreach calls year over year is not impacting outcomes as expected. • Many OB offices and primary care offices have reported being short-staffed since the pandemic began and therefore, addressing gaps in care has not been a priority as they navigate handling fully booked schedules on a weekly basis. This issue is evident in rural communities as well as urban communities. • Many OB offices still do not allow the mother to bring her other children or family to their appointments post-covid when historically, prenatal care has been a shared experience. • Transportation remains a barrier to rural women accessing health services even when offered transportation through an established vendor. The post-visit pick-up time can take over an hour resulting in less return visits for the member.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG Assessment: HSAG has determined that **Aetna Better Health of Michigan** addressed the prior year's recommendations within the annual PIP submission. The MHP accurately conducted statistical testing between the two PIP populations to establish an existing disparity between the two subgroups.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures

HSAG recommended the following:

- **Aetna Better Health of Michigan**'s performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators ranked below the 25th percentile, indicating children who turned 15 months old during the measurement year were not always getting at least six well-child visits with a PCP during their first 15 months of life. Additionally, children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life* measure.
- **Aetna Better Health of Michigan**'s performance for the *Cervical Cancer Screening* measure ranked below the 25th percentile, indicating women were not always being screened for cervical cancer. HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure.
- **Aetna Better Health of Michigan**'s performance for the *Breast Cancer Screening* measure ranked below the 25th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure.
- **Aetna Better Health of Michigan**'s performance for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked below the 25th percentile, indicating some members with diabetes did not have controlled blood pressure. HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled blood pressure. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator.
- **Aetna Better Health of Michigan**'s performance for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked below the 25th percentile, indicating some members with diabetes did not receive kidney health evaluations. HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.
- **Aetna Better Health of Michigan**'s performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years*, *Ages 18 to 21 Years*, and *Total* measure indicators ranked between the 25th percentile and 49th percentile, indicating some children were not always receiving one or more well-care visit during the

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
measurement year. HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits* measure. • **Aetna Better Health of Michigan**'s performance for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes were not having an HbA1c test performed during the measurement year. HSAG recommends that **Aetna Better Health of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have HbA1c testing. Upon identification of a root cause, **Aetna Better Health of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Well-Child Visits in the First 30 Months of Life • The health plan reviews claims/encounters to support medical record review for the analyses of service delivery provided to members. This strategy includes increasing member outreach and engagement efforts, implementation of new healthy behaviors reward platforms with health intelligence solution platforms. These initiatives allow members access to more choices for rewards than just a gift card and member interaction through local community partnerships and in-home service providers. • ABHMI provides Q4 federally qualified health center (FQHC) health event targeting W30 [Well-Child Visits in the First 30 Months of Life]. • Quarterly mailings are sent to non-compliant members encouraging them to visit their PCP for services. • The member incentive dollar amount for child and adolescent well care visits has increased from $25 to $50. • A targeted outreach program for new mothers to influence them to bring their children in for vaccines, lead screenings, and well visits has been initiated. • Healthcare Effectiveness Data and Information Set (HEDIS) Focused, Agile, Solutioning Team (FAST) work group meetings are ongoing with focus on the children's HEDIS measures utilizing specific, measurable, attainable, realist and timely (SMART) goals, and prioritization of disparate populations. • Non-compliant member lists are distributed monthly to providers and quarterly provider incentives are offered with details regarding what members did not obtain required services. Cervical Cancer Screening • Ongoing mailings are sent to non-compliant members encouraging them to obtain recommended cervical screenings. More robust and frequent mailings/outreach to those chronically non-compliant have been implemented.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures

- Continued member incentives of $50 gift cards are provided for cervical screenings.
- All women are referred to Health Outreach or Case Management for complex care issues to ensure optimal access to care and coordination.
- Participating and non-participating OB/GYNs are allowed to provide care without prior authorization for continuity of care in women's health initiatives.
- OB/GYNs are partnered with various health organizations and members to increase engagement and meet members in their own community.
- Efforts to improve the network of OB types in rural designated communities are ongoing.

Breast Cancer Screening

- The quality team supported two mobile mammogram events with Ascension Mobile Mammography Unit to improve health outcomes. Specific zip codes were targeted for members chronically non-compliant for mammogram services.
- Ongoing mailings are sent to non-compliant members encouraging them to obtain recommended breast health screenings. More robust and frequent mailings/outreach to those chronically non-compliant have been implemented.
- $50 gift card incentives for breast screenings continue.
- Participating and non-participating OB/GYNs are allowed to provide care without prior authorization for continuity of care in women's health initiatives.
- Multimodal outreach for breast cancer screening is ongoing.

Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

- CVS Health Tags are utilized to remind and encourage members to visit their primary providers and have their blood pressure checked.
- Mailers, text messages, and live outreach calls are utilized to encourage members to visit their primary care providers for blood pressure checks.
- Aetna has contracted with an in-home diabetic care health vendor that performs diabetic eye exams, HbA1c testing and blood pressure monitoring in the home of members. ABHMI provides monthly non-compliant member lists and the vendor performs the needed outreach to schedule the appointments for the members with gaps in care.

Kidney Health Evaluation for Patients With Diabetes

- Mailers, text messages, and live outreach calls are utilized to encourage members to visit their primary care providers.
- Provider education on appropriate billing practices and HEDIS measure review is ongoing.
- Medical record review data entry is reviewed regularly to identify and address gaps in care.

Child and Adolescent Well-Care Visits—Ages 12 to 17 Years, Ages 18 to 21 Years, and Total

- Live outreach calls and notification of screening events children up to age 17 are regularly utilized.
- Quarterly mailings to non-compliant members are sent encouraging them to visit their PCP for services, immunizations, and lead screening, if applicable.
- ABHMI provides Q4 (FQHC) health event targeting W30.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
• Ongoing HEDIS FAST work group meetings are utilized with focus on children's HEDIS measures with SMART goals, and prioritization of disparate populations. • Non-compliant member lists are distributed monthly to providers and quarterly provider incentives with details regarding which members did not obtain required services are sent. Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing RETIRED • CVS Health Tags are utilized to remind and encourage members to visit their primary providers and have their blood pressure checked. • Mailers, text messages, and live outreach calls are utilized to encourage members to visit their primary care providers for blood pressure checks. • Aetna has contracted with an in-home diabetic care health vendor that performs diabetic eye exams, HbA1c testing and blood pressure monitoring in the home of members. ABHMI provides monthly non-compliant member lists, and the vendor performs the needed outreach to schedule the appointments for the members with gaps in care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Well-Child Visits in the First 30 Months of Life • W30 (0-15 months) 5.25 % YOY improvement • W30 (15-30 months) 10.41% YOY improvement Cervical Cancer Screening • 1.22% YOY improvement Breast Cancer Screening • 0.91% YOY improvement Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) • 7.78% YOY improvement Kidney Health Evaluation for Patients With Diabetes • 3.29% YOY improvement Child and Adolescent Well-Care Visits—Ages 12 to 17 Years, Ages 18 to 21 Years, and Total • WCV [Child and Adolescent Well-Care Visits] 12-17 years 1.04% decline • WCV 18-21 years 0.17% YOY improvement • WCV Total 0.17% YOY improvement Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing RETIRED • HbA1c 2.43% YOY improvement

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures

c. Identify any barriers to implementing initiatives:

Well-Child Visits in the First 30 Months of Life

- For services rendered at practices, health plan does not receive the claim/encounter information (i.e., not the "payer of record," or not billing because "babies don't have insurance for the first 30 days").
- Parents do not adhere to scheduling six visits prior to 15 months of age
- Single mothers with multiple children can only schedule two children for well visits at a time (providers do not schedule appointments for more than two children so no-shows do not leave open appointments).
- Providers often miss opportunities to do a well-child visit when they have the child in the office for a sick child visit.
- Incorrect phone numbers are common along with ever-changing demographic info in Medicaid population.
- Use of emergency department (ED) and Urgent Care for non-emergency related care is frequent.
- Overarching transportation issues remain a constant barrier.

Cervical Cancer Screening

- Inaccurate member contact information makes outreach and education difficult for chronically non-compliant members (i.e., 2 years no provider visit).
- There are not enough OB weekend or evening physician appointment dates available.
- There is a high number of 'walk-in' clinics in Wayne County and the wait time can be long versus wait time with scheduled appointments. PCP/OBs are hesitant to schedule appointments due to high no-show rates that result in loss of revenue.
- Cultural differences and religious preferences often prevent some healthcare screenings.
- PCP auto assignment and the member are not appropriately engaged with the provider or office for continuity.
- Overarching transportation issues remain a constant barrier.
- ED/urgent care usage over preventative care is prevalent.
- SDoH often take precedence over health care needs.

Breast Cancer Screening

- Inaccurate member contact information makes outreach and education difficult for chronically non-compliant members (i.e.,2 years no provider visit).
- There are not enough weekend or evening physician appointment dates available.
- There is a high rate of no-show appointments scheduled during outreach events.
- There is a high number of 'walk-in' clinics in Wayne County and the wait time can be long versus wait time with scheduled appointments. PCP/OBs are hesitant to schedule appointments due to high no-show rates that result in loss of revenue.
- Cultural differences and religious preferences often prevent some healthcare screenings.
- PCP auto assignment and the member are not appropriately engaged with the provider or office for continuity.
- Members often fail to follow through with PCP referrals that are scheduled with radiology departments.
- Overarching transportation issues remain a constant barrier.
- ED/urgent care usage over preventative care is prevalent.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures

- SDoH often take precedence over health care needs.

Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)

- There are not enough weekend or evening physician appointment dates available.
- There is a high number of 'walk-in' clinics in Wayne County and the wait time can be long versus wait time with scheduled appointments. PCP/OBs are hesitant to schedule appointments due to high no-show rates that result in loss of revenue.
- Cultural differences and religious preferences often prevent some healthcare screenings.
- PCP auto assignment and the member are not appropriately engaged with the provider or office for continuity.
- Overarching transportation issues remain a constant barrier.
- ED/urgent care usage over preventative care is prevalent.
- SDoH often take precedence over health care needs.
- Provider does not bill appropriately for the result of the blood pressure (BP) reading.
- Per HEDIS tech specifications, the last BP of the year is the only BP reading that counts for compliance; therefore, measurement is heavily reliant on medical record review.
- Inaccurate member contact information makes outreach and education difficult for chronically non-compliant members.

Kidney Health Evaluation for Patients With Diabetes

- Inaccurate member contact information makes outreach and education difficult for chronically non-compliant members.
- There are not enough weekend or evening physician appointment dates available.
- PCP auto assignment and the member are not appropriately engaged with the provider or office for continuity.
- Overarching transportation issues remain a constant barrier.
- ED/urgent care usage over preventative care is prevalent.
- SDoH often take precedence over health care needs.
- Providers only complete a urine albumin-creatinine ratio (uACR) without the estimated glomerular filtration rate (eGFR) giving an incomplete assessment of kidney health.
- More robust provider education is needed.

Child and Adolescent Well-Care Visits—Ages 12 to 17 Years, Ages 18 to 21 Years, and Total

- Single mothers with multiple children can only schedule two children for well visits at a time (providers do not schedule appointments for more than two children so no-shows do not leave open appointments).
- Providers often miss opportunities to do a well-child visit when they have the child in the office for a sick child visit.
- Incorrect phone numbers are common along with ever-changing demographic info in Medicaid population.
- Use of ED and Urgent Care for non-emergency related care is frequent.
- Overarching transportation issues remain a constant barrier.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing RETIRED • Providers do not fill the current procedural terminology (CPTII) code to the health plan providing results of A1C test • ABHMI does not incentivize providers for billing CPTII codes. • The last A1C of the year must be controlled (less than 8) to count toward compliance. • JVHL is ABHMI's only participating laboratory vendor (Quest and LabCorp are non-participating vendors.) • HBD [Hemoglobin A1c Control for Patients with Diabetes] is heavily reliant on medical record data collection efforts. • Inaccurate member contact information makes outreach and education difficult for chronically non-compliant members.
HSAG Assessment: HSAG has determined that **Aetna Better Health of Michigan** has partially addressed the prior year's recommendations. **Aetna Better Health of Michigan** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life* measure indicators. Although both measure indicators continued to rank below the 25th percentile, the measure indicators demonstrated a statistically significant improvement and rate increase from the prior measurement year. This rate improvement may be due in part to **Aetna Better Health of Michigan**'s targeted interventions, such as facilitating a FQHC health event with a focus on the measure indicators, quarterly mailings sent to members encouraging them to schedule a well-child visit with their PCP, member and provider incentives for completing well-child visits, implementation of an outreach program for new mothers to encourage PCP engagement and appointment continuance, and strategic development of HEDIS FAST workgroup meetings with an ongoing focus on children's HEDIS measures. Barriers noted by **Aetna Better Health of Michigan** included not receiving some claim or encounter information from service providers, frequent utilization of emergency department or urgent care for non-emergency medical services by parents, single mothers with multiple children only being able to schedule two children at a time for well-child visits, incorrect member demographic information, and missed opportunities by PCPs to complete well-child visits when children were in the office for sick visits. HSAG recommends continued efforts by **Aetna Better Health of Michigan** to further improve the *Well-Child Visits in the First 30 Months of Life* rates and monitoring of initiatives currently in place to ensure improved performance. **Aetna Better Health of Michigan** could consider sharing best practices with PCPs on proper billing. Regarding HSAG's prior year recommendation for the *Cervical Cancer Screening* measure, **Aetna Better Health of Michigan** has demonstrated efforts by increasing the frequency of mail sent to noncompliant members for the purpose of encouraging completion of cervical screenings, member incentives for completion of cervical screenings, partnership with various health organizations to increase engagement and community outreach, and allowing participating and non-participating OB/GYNs to provide care without prior authorization for continuity of women's healthcare. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for the *Cervical Cancer Screening* measure by ranking below the 25th percentile for MY 2022. Several barriers noted by **Aetna Better Health of Michigan** included non-engagement of some members with auto-assigned PCPs, inaccurate member demographic information, appointment availability on weekends or evenings, transportation issues, and cultural and religious factors preventing some healthcare screenings. HSAG therefore recommends that **Aetna Better Health of Michigan** continue its efforts on increasing cervical cancer screenings and monitor the impact of initiatives currently in place to ensure improved performance. **Aetna Better Health of Michigan** could consider the development and deployment of a

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints. Pertaining to HSAG's prior year recommendation for the *Breast Cancer Screening* measure, **Aetna Better Health of Michigan** has demonstrated efforts by hosting mobile mammogram events targeting ZIP Codes with high saturations of chronic non-compliancy for mammogram services, providing member incentives for completed breast cancer screenings, and utilization of multimodal outreach for breast cancer screenings. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for the *Breast Cancer Screening* measure by ranking between the 25th and 49th percentile for MY 2022. Limited weekend or evening appointment options and high no-show rates for appointments were some barriers identified by **Aetna Better Health of Michigan**. HSAG therefore recommends that **Aetna Better Health of Michigan** continue its efforts on increasing breast cancer screenings and monitor the impact of initiatives currently in place to ensure improved performance. **Aetna Better Health of Michigan** could consider the development and deployment of a digital notification system for members needing breast cancer screening and incorporating screening reminders into current care coordination member touchpoints. Regarding HSAG's prior year recommendation for the *Comprehensive Diabetes Care—Blood Pressure Control (<1490/90 mm Hg)* measure, **Aetna Better Health of Michigan** has demonstrated efforts by contracting with an in-home diabetic healthcare vendor that performs diabetic eye exams, HbA1c testing, and blood pressure monitoring in the home of members who have been identified as noncompliant and conducting various methods of member outreach. Additionally, the rate for the *Comprehensive Diabetes Care—Blood Pressure Control (<1490/90 mm Hg)* measure significantly improved in comparison with the prior measurement year. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for the *Comprehensive Diabetes Care—Blood Pressure Control (<1490/90 mm Hg)* measure by ranking between the 25th and 49th percentile for MY 2022. HSAG therefore recommends that **Aetna Better Health of Michigan** continue its efforts on further improving the *Comprehensive Diabetes Care—Blood Pressure Control (<1490/90 mm Hg)* rate and monitoring the impact of initiatives currently in place to ensure improved performance. Pertaining to HSAG's prior year recommendation for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators, **Aetna Better Health of Michigan** has demonstrated efforts by conducting various methods of outreach to encourage members to visit their PCPs, giving education to providers on appropriate billing practices, and reviewing medical record review data entry to identify and address gaps in care. However, **Aetna Better Health of Michigan** continues to demonstrate low performance for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators, as all measure indicators ranked below the 25th percentile, except measure indicator *Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years*, which ranked between the 25th and 49th percentile for MY 2022. HSAG therefore recommends that **Aetna Better Health of Michigan** continue its efforts on further improving the *Kidney Health Evaluation for Patients With Diabetes* measure indicators and monitor the impact of initiatives currently in place to ensure improved performance. Relating to HSAG's prior year recommendation for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years, Ages 18 to 21 Years*, and *Total* measure indicators, **Aetna Better Health of Michigan** has demonstrated efforts by increasing its member outreach, conducting ongoing internal workgroup meetings, and giving incentives to providers. However, **Aetna Better Health of Michigan** continues to demonstrate low

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
performance, as the *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years*, *Ages 18 to 21 Years*, and *Total* measure indicators ranked between the 25th percentile and 49th percentile, and below the 25th percentile for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* measure indicator for MY 2022. Several barriers noted by **Aetna Better Health of Michigan** included single mothers with multiple children only being allowed to schedule two children for well-child visits at a time, missed opportunities by PCPs to complete well-child visits when children are in the office for sick visits, frequent utilization of emergency department or urgent care for non-emergency medical services by parents, and transportation issues. HSAG therefore recommends that **Aetna Better Health of Michigan** continue its efforts on increasing well-child visits and monitor the impact of initiatives currently in place to ensure improved performance. Pertaining to HSAG's prior year recommendation for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure, **Aetna Better Health of Michigan** has demonstrated efforts by contracting with an in-home diabetic healthcare vendor that performed HbA1c testing in the home of members who were identified as noncompliant. However, since rates were not reported due to NCQA retiring the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure in MY 2022, and performance could not be evaluated, HSAG recommends that **Aetna Better Health of Michigan** continue its efforts on further improving intervention and management of diabetes.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Aetna Better Health of Michigan** scored below the statewide average in the MIS standard. The MHP received a *Not Met* score for elements *5.6 Pharmacy/MCO Common Formulary* and *5.11 Claims Processing (Non-Pharmacy)*. As **Aetna Better Health of Michigan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **Aetna Better Health of Michigan** ensure its CAP is fully implemented to mitigate the deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: 5.6 Pharmacy/MCO Common Formulary • Aetna immediately implemented a monthly monitoring strategy which reviewed all claims for the first week of every month. All rejected claims were compared to multiple formulary listings (MPPL [Michigan Preferred Product List], Common Formulary, and preferred drug list [PDL]) to ensure proper reject messaging. This strategy allows for the opportunity to proactively correct coding to • ensure member access to their pharmacy benefit. • Since this process implementation, our monthly retrospective claims review has found unintentional coding discrepancies which we have been able to share with the common formulary workgroup, MDHHS, and other health plan partners. Including opportunities to expand care to members. 5.11 Claims Processing (Non-Pharmacy) • Aetna immediately implemented a monthly monitoring strategy which reviewed all Non-Pharmacy claims for the first week of every month. All rejected claims are reviewed and validated for accuracy.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): 5.6 Pharmacy/MCO Common Formulary • Throughout the year, this process improvement has yielded positive results. We have been able to identify NDC [National Drug Code] discrepancies and alerted MDHHS to help them correct the coding for a couple of products. This process has also helped identify new GPIs [undefined acronym] that entered our database file sooner than the database used by MDHHS, which we notified MDHHS so they may update the file. The Pharmacy PA [prior authorization] team continues to utilize the online formulary listing for common formulary and PDL listings, leading to accurate exception request reviews. 5.11 Claims Processing (Non-Pharmacy) • Further Non-Pharmacy claims accuracy, timeliness and validation checks are being explored. We will have additional improvement efforts to report on in our next update.
c. Identify any barriers to implementing initiatives: 5.6 Pharmacy/MCO Common Formulary • Potential barriers remain with the manual coding nature of the common formulary/PDL (due to the lack of an NDC file provided by the state), and with discrepancies between FDB [undefined acronym] and Medi-span databases. The lag period between updates to coding remain an obstacle to accuracy. 5.11 Claims Processing (Non-Pharmacy) • There were no significant barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that **Aetna Better Health of Michigan** addressed the prior year's recommendation. The SFY 2023 compliance review activity confirmed that **Aetna Better Health of Michigan** received a *Met* score for element 5.6. While **Aetna Better Health of Michigan** received a *Satisfied* score (as opposed to a *Met* score) for element 5.11 during the SFY 2023 compliance review activity, the reporting months of noncompliance occurred prior to the issuance of a prior CAP. **Aetna Better Health of Michigan** was compliant in subsequent reporting months after the implementation of the MHP's remediation steps.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • Only 77 percent of the responsive cases reported that the location offered services for the requested specialty. **Aetna Better Health of Michigan**'s provider data matched the online provider directory; however, the directory information was not confirmed by the provider's office staff members. The mismatch indicates inaccurate provider information within the provider data and/or online provider directory as it relates to the location's specialty. HSAG recommends that **Aetna Better Health of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect specialty information) to address the provider data deficiencies. • Of the survey respondents that offered the correct specialty, only 68.5 percent were affiliated with the sampled provider listed in **Aetna Better Health of Michigan**'s online provider directory. **Aetna Better Health of Michigan**'s provider data matched the online provider directory; however, the directory information was not confirmed by the location's office staff members. The mismatch indicates inaccurate provider information within the provider data and/or online provider directory as it relates to the provider's location (i.e., address). HSAG recommends that **Aetna Better Health of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect location information) to address the provider data deficiencies.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Aetna has implemented actions to improve provider directory accuracy that include PCP quarterly auditing and deploying a 4275 Pre-Screen validation front end audit to scan and ensure no provider information is captured that does not have a positive participation status or other required information for file inclusion. This will reduce and thus eliminate any passage of data to MDHHS for providers who should not be reflected as participating or accepting new patients. The quarterly audits have been completed and data has been compiled.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Our internal Q3 2023 Quarterly audit shows 65% accuracy for providers accepting new patients and 78% validated address and phone number which exceeds the 43.5% Secret Shopper calls initiated by HSAG.
c. Identify any barriers to implementing initiatives: • There were no significant barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that **Aetna Better Health of Michigan** addressed the prior year's recommendations, as the MHP noted that it has implemented actions to improve provider directory accuracy. However, the MHP should continue to initiate efforts to ensure provider directory accuracy.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG recommended the following: **Adult and Child Medicaid** • HSAG recommends that **Aetna Better Health of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur. **CSHCS** • HSAG recommends that **Aetna Better Health of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur. **HMP** • HSAG recommends that **Aetna Better Health of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Adult and Child Medicaid • Communicate CAHPS results with Providers/Specialists, and Care Coordinators to increase awareness of opportunities to support members in navigating health care outside of what is shared on our website,

5. Prior Year Recommendation From the EQR Technical Report for CAHPS

and in our provider newsletters. A more focused approach to ensure understanding of the measurements/metrics and how they are being assessed.

- Community Health Workers (CHWs) and Member Outreach Coordinators now required to use Health Care Equity assessments to identify and document SDoH and coordinate referrals to community-based organizations (CBOs) that report results in closed loop platforms (incentivizing CBOs to use specific platforms that offer closed loop functionality) so we can ensure the members needs are being met and refer to the CBOs with successful outcomes.
- Monitor for consistent use of the voluntary post call experience rating survey available to members after each telephone call with their Care Coordinators.
- Expand and leverage telehealth technologies to expand access to care to our members that may not be aware of the ease of use from a smart phone. Also, incentivize providers reluctant to expand use of telemedicine appointments post pandemic to continue doing so.
- Gain member feedback from the Member Advisory Committee and other Focus Study groups about areas of improvement with the health plan and network providers.
- A CAHPS supplemental IVR survey will be deployed in Q4 to identify trends in barriers to care.

Children's Special Health Care Services (CSHCS)

- The coordination of care between primary and specialist providers can be a challenge and may affect patient perceptions of their specialist care. Improving the coordination of care and case management can increase patient satisfaction with their specialist. To improve care coordination efficiency and quality to the CSHCS members, ABH MI is putting processes in place to:
- Communicate CAHPS results with Providers/Specialists to increase provider awareness of opportunities to support members in navigating health care outside of what is shared on our website, and in our provider newsletters. A more focused approach to ensure understanding of the measurement and how they are being assessed.
- Ensure referrals and services delivered by the providers/specialists for the CSHCS population are being tracked by the MHP Care Coordinators and follow up occurs to ensure the members needs were met after the referral is given.
- Through Care Coordination and Population Health Management, assist the CSHCS members on how to prepare, and ensure effective communication with their providers such as writing down talking points and questions prior to visits.

Healthy Michigan Plan (HMP)

- Communicate CAHPS results with Providers/Specialists, and Care Coordinators to increase awareness of opportunities to support members in navigating health care outside of what is shared on our website, and in our provider newsletters. A more focused approach to ensure understanding of the measurements/metrics and how they are being assessed.
- CHWs and Member Outreach Coordinators now required to use Health Care Equity assessments to identify and document SDoH and coordinate referrals to CBO's that report results in closed loop platforms (incentivizing CBOs to use specific platforms that offer closed loop functionality) so we can ensure the members needs are being met and refer to the CBOs with successful outcomes.
- Monitor for consistent use of the voluntary post call experience rating survey available to members after each telephone call with their Care Coordinators.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
• Expand and leverage telehealth technologies to expand access to care to our members that may not be aware of the ease of use from a smart phone. Also, incentivize providers reluctant to expand use of telemedicine appointments post pandemic to continue doing so. • Gain member feedback from the Member Advisory Committee and other Focus Study groups about areas of improvement with the health plan and network providers. • A CAHPS supplemental IVR survey will be deployed in Q4 to identify trends in barriers to care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The ABHMI response rate to CAHPS surveys increased YOY providing broader insight into member experiences, access to care, and access to providers.
c. Identify any barriers to implementing initiatives: • When ABHMI supplemental CAHPS campaign in deployed, we are dependent on member responses to IVR surveys. • Provider responsiveness to ABHMI CAHPS education in sharing our outcomes.
HSAG Assessment: HSAG has determined that **Aetna Better Health of Michigan** has addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **Aetna Better Health of Michigan**'s score for *Access to Prescription Medicines* was statistically significantly higher than the 2022 NCQA child Medicaid national average for the CSHCS population. Furthermore, scores were comparable to national averages and the 2022 top-box scores for all measures for the adult and child Medicaid, CSHCS, and HMP populations.

Blue Cross Complete of Michigan

Table 4-2—Prior Year Recommendations and Responses for BCC

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although there were no identified weaknesses, HSAG recommends **Blue Cross Complete of Michigan** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Although there were no identified weaknesses for Blue Cross Complete's (BCC) Performance Improvement Project (PIP) submission, based on recommendations, BCC completed a Key Driver Analysis to identify barriers to care. In response to the analysis, BCC initiated the following interventions to timely address identified barriers. The Key Driver Analysis process included review of Member Survey outcomes. • Identified pregnant Black women as a higher risk population for priority high-touch, early case management outreach. • Established a handoff process from the BCC Case Management team to the BCC Community Outreach team for door-to-door outreach. • Established Community Pregnancy Groups as safe spaces for pregnant Black women to get trusted peer-led education about prenatal care. • Launched a social media campaign with prenatal messaging for the focus population. • All initiatives are still underway.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Results of the initiatives include: • 100% of pregnant, Black women in Wayne County were identified as a high-risk population, receiving expedited high touch and early outreach. • The process for the BCC Case Management team to refer pregnant women to the BCC Community Outreach team was successfully launched. • Community Pregnancy Groups are in place and participation is steadily increasing. • The social media campaign that was launched is meeting goals for number of views and audience reach. • Performance Improvement Project data showed improvement over baseline rate for the disparate subgroup. • The racial disparity between Black and white women for timeliness of pre-natal care in Wayne County decreased from Measurement Year (MY) 2021 to MY2022.
c. Identify any barriers to implementing initiatives: • No barriers identified; all interventions were successfully implemented.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG Assessment: HSAG has determined that **Blue Cross Complete of Michigan** addressed the prior year's recommendation. The MHP used appropriate methods for conducting its causal/barrier analysis and initiated interventions in a timely manner to address those barriers.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **Blue Cross Complete of Michigan**'s performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. HSAG recommends that **Blue Cross Complete of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Blue Cross Complete of Michigan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. • **Blue Cross Complete of Michigan**'s performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. HSAG recommends that **Blue Cross Complete of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **Blue Cross Complete of Michigan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure. • **Blue Cross Complete of Michigan**'s performance for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. HSAG recommends that **Blue Cross Complete of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Blue Cross Complete of Michigan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: BCC conducted a root cause analysis to determine why some children did not receive timely well-child visits. All initiatives are still underway: • Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30). o Telephonic and Door to Door outreach o Member texting campaigns o Social media posts o Member and provider newsletter articles

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
○ Reminders to Maternal Infant Health Program providers to educate parents about need for well-child care • Breast Cancer Screening ○ Telephonic and Door to Door outreach ○ Member texting campaigns ○ Social media posts ○ Member and provider newsletter articles • Kidney Health Evaluation for Patients With Diabetes ○ BCC contracted with a remote monitoring vendor that offers live outreach and empowers members to be in compliance with their care. ○ Dedicated BCC Care Connector outreaching to members with >8HbA1c and provides education and support for diabetes care. ○ Member texting campaigns to educate members about importance of diabetes care. ○ Social media posts to educate members about importance of diabetes care. ○ Member and provider newsletter articles to educate members and remind providers of the importance of diabetes care.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • W30 2 or more well-child visits ○ Rate increased .66 percentage points from MY 2021 to MY 2022 • Breast Cancer Screening ○ Rate increased 1.04 percentage points from MY 2021 to MY 2022 • Kidney Health evaluation ○ Rate increased 6.77 percentage points from MY 2021 to MY 2022
c. Identify any barriers to implementing initiatives: • No barriers identified; all interventions were successfully implemented.
HSAG Assessment: HSAG has determined that **Blue Cross Complete of Michigan** has partially addressed the prior year's recommendations. **Blue Cross Complete of Michigan** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator by facilitating telephonic and community-based member outreach, conducting member texting campaigns, utilizing social media posts, and distributing newsletters to members and providers. **Blue Cross Complete of Michigan** also conducted a root cause analysis to determine why some children did not receive timely well-child visits, but no barriers or root causes were noted. While the rate increased slightly from the prior measurement year, **Blue Cross Complete of Michigan** continues to demonstrate low performance for the measure by ranking between the 25th and 49th percentile for MY 2022. Therefore, the interventions utilized to improve the rate may or may not be directly impacting the root cause of the measure's low performance. HSAG recommends continued efforts by **Blue Cross Complete of Michigan** to further improve performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator and monitoring of initiatives currently in place to ensure improved performance. HSAG has determined that **Blue Cross Complete of Michigan** addressed the prior year's recommendation for the *Breast Cancer Screening* measure. **Blue Cross Complete of Michigan** conducted a root cause analysis to

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
determine why some women were not being screened for breast cancer and implemented initiatives such as facilitating telephonic and community-based member outreach, conducting member texting campaigns, utilizing social media posts, and distributing newsletters to members and providers. While no barriers or root causes were noted, the rate increased slightly from the prior measurement year and ranked between the 50th and 74th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **Blue Cross Complete of Michigan** addressed the prior year's recommendation for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators. **Blue Cross Complete of Michigan** conducted a root cause analysis to determine why some members with diabetes were not receiving kidney health evaluations and implemented initiatives such as contracting with a remote monitoring vendor to provide live outreach, conducting member texting campaigns, utilizing social media posts, distributing newsletters to members and providers, conducting member outreach, and providing member education. While no barriers or root causes were noted, the rate increased significantly for three of the four measure indicators (*Ages 18 to 64 Years*, *Ages 65 to 74 Years*, and *Total*) from the prior measurement year and all measure indicators ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • HSAG did not identify any substantial weaknesses for **Blue Cross Complete of Michigan** through the compliance review activity; therefore, no recommendations were made.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: •
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): •
c. Identify any barriers to implementing initiatives: •
HSAG Assessment: This section is not applicable as HSAG did not identify any substantial weaknesses for **Blue Cross Complete of Michigan** through the SFY 2022 compliance review activity; therefore, no recommendations were made.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • Only 64.7 percent of the sampled provider locations could be reached. In addition to the limitations related to the secret shopper approach, **Blue Cross Complete of Michigan**'s provider data included invalid telephone or address information when contacting the office staff members. HSAG recommends that **Blue Cross Complete of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
• Of cases in which the survey respondent reported that the provider location accepted **Blue Cross Complete of Michigan**, Medicaid, and new patients, 81 percent of cases offered the caller an appointment date. However, pediatric providers had an appointment availability rate of 77.8 percent, while OB/GYN provider locations had an appointment availability rate of 66.7 percent. For new **Blue Cross Complete of Michigan** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. HSAG recommends that **Blue Cross Complete of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Blue Cross Complete of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • BCC educates the provider network on appointment availability standards and conducts provider recruitment and contracting activities based on regular review of network adequacy of the provider network. • Secret Shopper o BCC utilizes the case-level analytic data files containing provider deficiencies identified during the survey to identify deficiencies to update provider records with accurate data. o BCC also performs Provider Director Accuracy mailings that are done quarterly to identify changes that are needed. o BCC utilizes changes identified by Provider Network Management in Joint Operating Committee meetings with the provider. o BCC researches the deficiencies identified during the survey to confirm that updates sent by the provider were not inadvertently overlooked by BCC. To date, BCC has not found a single instance where the provider notified BCC of the change and the Plan did not make the update. • Provider Access and Availability o BCC will conduct the next annual access and availability survey. The anticipated survey dates are October 2023 – November 2023. Providers who are non-compliant with access and availability standards as set by BCC will be subjected to a corrective action plan and required to respond to the plan within 30 days. o BCC will continue to publish access and availability standards, best practices and Plan survey results in the provider newsletter. o BCC will include access standards in the meeting packet of the Plan's virtual provider conference scheduled for October 12, 2023, as an additional reminder.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • BCC resurveyed a random sample size of 50 providers that were non-compliant the previous year with access and availability standards. Results concluded that 46% of providers re-surveyed had updated their processes and were compliant. BCC will continue to monitor non-compliant providers to help ensure all access and availability standards are met.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
c. Identify any barriers to implementing initiatives: • The biggest barrier that BCC has identified is that the providers are not providing notification to BCC when there are changes in their demographic information. • No barriers noted for access and availability initiatives.
HSAG Assessment: HSAG has determined that **Blue Cross Complete of Michigan** addressed the prior year's recommendation, as noted through its efforts to monitor provider data. However, the MHP should continue to monitor its provider network through the annual access and availability survey process and take corrective action as necessary for noncompliant providers.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG recommended the following: **Adult and Child Medicaid** • HSAG recommends that **Blue Cross Complete of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur. **CSHCS** • **Blue Cross Complete of Michigan**'s 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Customer Service*. Parents/caretakers of child members enrolled in **Blue Cross Complete of Michigan** may not be receiving the information or help needed, or may be dissatisfied with the level of courtesy and respect offered by customer service. HSAG recommends that **Blue Cross Complete of Michigan** explore the drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **Blue Cross Complete of Michigan** should consider obtaining direct patient feedback from members to drill down into areas that need improvement. **HMP** • HSAG recommends that **Blue Cross Complete of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • BCC developed several surveys to aid in the ongoing collection of member feedback to assist in the identification of trends and recurring issues to enable actions that will help improve member experience. Surveys developed: o Post Appointment survey – conducted throughout text campaign. Survey response is completed by member after provider appointment. o Member Feedback survey – member experience survey accessible on website where member can provide feedback on experience with BCC. o Children's Special Health Care Services survey – targeted member experience survey through text campaign.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
• BCC's CAHPS workgroup meets monthly to review CAHPS results, identify low performing measures, identify drivers, monitor measures and develop initiatives in an effort to help ensure significant decreases in scores over time do not occur.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Surveys implemented 2nd and 3rd quarter 2023. BCC is currently aggregating responses and reviewing feedback.
c. Identify any barriers to implementing initiatives: • BCC continues to be challenged with contacting members and getting them to complete the surveys. • BCC Member abrasion due to the number of text communications received from the plan. • BCC is currently reviewing frequency of requests of members to complete surveys when member has frequent provider appointments.
HSAG Assessment: HSAG has determined that **Blue Cross Complete of Michigan** has partially addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **Blue Cross Complete of Michigan**'s score for *Customer Service* for the CSHCS population was comparable to the 2022 NCQA child Medicaid national average. The score for *How Well Doctors Communicate* was statistically significantly higher than the 2022 NCQA child Medicaid national average for the child Medicaid population and the *How Well Doctors Communicate*, *Coordination of Care*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* scores were statistically significantly higher than the 2022 NCQA adult Medicaid national average for the HMP population; however, the score for *Rating of Personal Doctor* for the adult Medicaid population was statistically significantly lower than the 2022 NCQA adult Medicaid national average. HSAG recommends that **Blue Cross Complete of Michigan** continue to implement performance improvement interventions and evaluate their effectiveness.

HAP Empowered

Table 4-3—Prior Year Recommendations and Responses for HAP

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although there were no identified weaknesses, HSAG recommends **HAP Empowered** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: HAP Empowered evaluates each intervention by reviewing HEDIS results and comparing baseline to remeasurement periods. All interventions are tracked to determine if the intervention had an impact on the rate. Interventions include: • Implemented a maternity focused care management program powered by ProgenyHealth. Progeny also outreaches to engage members and refer to Maternal Infant Health Program (MIHP). • Continued strategies to engage members and educate on incentive program. • Implemented text messaging campaign to engage members. • Referrals and Enrollment in the Maternal Infant Health Program.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Below is a summary of effectiveness of interventions during remeasurement 1: • Of members enrolled in the maternity program, 16/22 (72.72%), received timely prenatal care. • 121/197 (61.42%) received the member incentive mailing. Of those that received the mailing, 84/121 (69.42%) had timely prenatal care and earned the incentive. • For members enrolled in text messaging, 76/197 (38.57%) received a text message incentive reminder. Of those that received a text message, 64/76 (84.21%) had timely prenatal care and earned the incentive. • 34/197 (17.25%) members enrolled in the MIHP program. Of those enrolled, 26/34 (76.47%), received timely prenatal care. The overall HEDIS MY2022 prenatal care rate is 79.21% which is an increase of 3.41 percentage points compared to the baseline rate of 75.8%. HAP Empowered further compared the study indicator of the Black/African American remeasurement 1 rate to the baseline rate. The Black/African American baseline results are 157 out of 217 (72.35%) members received timely prenatal care compared to 148 out of 197 (75.13%) in remeasurement period 1.
c. Identify any barriers to implementing initiatives: HAP Empowered determined that there are continued barriers responsible for members not accessing prenatal care. These barriers include: • Member Outreach/Engagement   ○ Unable to reach member (lack of correct contact information/member does not answer call) • SDoH

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
○ Income/poverty, job status and education as well as psychosocial factors of chronic stress and lack of social support
HSAG Assessment: HSAG has determined that **HAP Empowered** addressed the prior year's recommendation. The MHP revisited its causal/barrier analysis to identify barriers to care and developed targeted intervention strategies.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures

HSAG recommended the following:

- **HAP Empowered**'s performance for both *Well-Child Visits in the First 30 Months of Life* measure indicators ranked below the 25th percentile, indicating children who turned 15 months old during the measurement year were not always getting at least six well-child visits with a PCP during their first 15 months of life. Additionally, children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life* measure.
- **HAP Empowered**'s performance for the *Cervical Cancer Screening* measure ranked below the 25th percentile, indicating women were not always being screened for cervical cancer. HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure.
- **HAP Empowered**'s performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Total* measure indicators ranked below the 25th percentile, and *Ages 3 to 11 Years* and *Ages 18 to 21 Years* measure indicators ranked between the 25th percentile and 49th percentile, indicating some children were not always receiving one or more well-care visit during the measurement year. HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits* measure.
- **HAP Empowered**'s performance for the *Chlamydia Screening in Women—Ages 21 to 24 Years* measure indicator ranked between the 25th percentile and 49th percentile, indicating some women 21 to 24 years of age identified as sexually active did not receive at least one test for chlamydia during the measurement year. HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some women identified as sexually active did not receive testing for chlamydia. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Chlamydia Screening in Women—Ages 21 to 24 Years* measure indicator.
- **HAP Empowered**'s performance for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have controlled HbA1c levels. HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled HbA1c levels. Upon identification of a root cause, **HAP Empowered**

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators. • **HAP Empowered**'s performance for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have an eye exam to screen or monitor for diabetic retinal disease. HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some members with diabetes did not have an eye exam performed. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator. • **HAP Empowered**'s performance for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have controlled blood pressure. HSAG recommends that **HAP Empowered** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled blood pressure. Upon identification of a root cause, **HAP Empowered** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Related to the Well-Child Visits in the First 30 Months of Life measure and the Child and Adolescent Well-Care Visits measures: o HAP Empowered hired two Health Outreach Specialists who telephonically outreached to members that were due for well-child visits by the end of the year. During these outreaches, the health outreach specialists reminded members of the preventive care that they were due to complete, provided education around these services, identified and addressed social determinants of health barriers, and assisted in scheduling doctor appointments and transportation (as needed). o HAP Empowered delivers gaps in care letters to members to remind members of any open gaps and in addition conducted a mass mailing to deliver a postcard to remind members to schedule a well visit with their doctor. o HAP Empowered revamped the reward program and offers a $50 reward when members complete a doctor's visit. • Related to the Cervical Cancer Screening (CCS) measure and the Chlamydia Screening in Women (CHL) measure: o HAP Empowered continues to implement women's events focused on providing needed screenings while growing partnerships with providers. o HAP Empowered offers a $50 reward for members that complete an annual doctor visit with our approach to assist getting members into their doctor office where preventative services can be completed such as cervical cancer screening and chlamydia screening. • Related to Comprehensive Diabetes Care HbA1c measures: o HAP Empowered partners with Everly Health to send members without an HbA1c result an in-home testing kit.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
○ HAP Empowered partnered with Matrix Medical to complete in-home diabetic eye exams and if members are due for HbA1c testing, Matrix will do an in-person HbA1c test with the member. ○ HAP Empowered collected additional supplemental data sources (ex. Michigan Health Information Network Shared Services [MiHIN] and Henry Ford) to ensure when a lab test was billed that a lab result was also received for data collection and rate reporting.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Related to the Well-Child Visits in the First 30 Months of Life: ○ W30: 6+ Visits in First 15 Months of Life final MY 2021 performance rate was 36.06% and the final MY 2022 rate increased significantly to 52.44% which improved by 16 percentage points. In addition, HAP Empowered continues to see improvement for MY 2023 with the current performance rate at 51.17% (data through August). ○ W30: 2 + Visits in between 15-30 Months final MY 2021 performance rate was 46.05% and the final MY 2022 rate was 47.35%. HAP Empowered continues to see significant improvement for MY 2023 with the current performance rate at 56.64% (data through August) which has improved approximately 10 percentage points since the final MY 2022 rate. • HAP Empowered's final CCS MY 2021 rate was 43.80% and improved by approximately 13 percentage points from the final MY 2022 rate which was 56.45%. • HAP Empowered's final CHL: Ages 21-24 Years MY 2021 rate was 60.48% and improved by approximately six percentage points from the final MY 2022 rate which was 65.78%. • Related to HAP Empowered Comprehensive Diabetes Care measures: ○ HbA1c Control (<8.0%) final MY 2021 rate was 44.28% and improved by 12 percentage points in MY 2022 rate with a final rate of 56.20%. ○ Eye Exams for Patients with Diabetes (EED) final MY 2021 rate was 49.88% and improved by nine percentage points in MY 2022 with a final rate of 58.88% ○ Blood Pressure Control for Patients with Diabetes (BPD) final MY 2021 rate was 53.28% and improved by eight percentage points in MY 2022 with a final rate of 61.07%.
c. Identify any barriers to implementing initiatives: • Missing, incorrect, or incomplete contact information results in unsuccessful member contact during member outreach. • Our partnership with Matrix on our diabetes care ended but HAP Empowered is actively looking into additional vendors that could continue in home diabetic eye exams. • Preventative screenings such as cervical cancer screening or chlamydia screenings may not be completed during doctor visit. • Social determinants of health including housing and food insecurity, income, type of employment, poverty, and education.
HSAG Assessment: HSAG has determined that **HAP Empowered** has partially addressed the prior year's recommendations. **HAP Empowered** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life* measure indicators by hiring additional outreach specialists to conduct outreach to members due for well-child visits, sending gaps in care letters to members, providing education to members, offering member incentives, and addressing SDOH barriers by assisting with scheduling doctor appointments and transportation when needed. **HAP Empowered** also conducted a root cause analysis to determine why some children did not receive timely well-child visits and identified incomplete contact information and SDOH as barriers. While both measure indicator rates increased from the prior measurement

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
year, **HAP Empowered** continues to demonstrate low performance for both measure indicators, with the *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator ranking between the 25th and 49th percentile and *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator ranking below the 25th percentile for MY 2022. Therefore, the interventions utilized to improve the rate may or may not be directly impacting the root cause of the measure's low performance. HSAG recommends continued efforts by **HAP Empowered** to further improve performance for the *Well-Child Visits in the First 30 Months of Life* measure indicators and monitoring of initiatives currently in place to ensure continued improved performance. Regarding HSAG's prior year recommendation for the *Cervical Cancer Screening* measure, **HAP Empowered** has demonstrated efforts by implementing women's events to provide needed screening, growing partnerships with providers, and offering member incentives. Additionally, the rate for the *Cervical Cancer Screening* measure significantly improved in comparison with the prior measurement year. However, **HAP Empowered** continues to demonstrate low performance for the *Cervical Cancer Screening* measure by ranking between the 25th and 49th percentile for MY 2022. HSAG therefore recommends that **HAP Empowered** continue its efforts on further improving the *Cervical Cancer Screening* rate and monitoring the impact of initiatives currently in place to ensure improved performance. Pertaining to HSAG's prior year recommendation for the *Child and Adolescent Well-Care Visits* measure indicators, **HAP Empowered** has demonstrated efforts by hiring additional outreach specialists to conduct outreach to members due for well-child visits, sending gaps in care letters to members, providing education to members, offering member incentives, and addressing SDOH barriers by assisting with scheduling doctor appointments and transportation when needed. **HAP Empowered** also conducted a root cause analysis to determine why some children did not receive timely well-child visits and identified incomplete contact information and SDOH as barriers. Additionally, the rates for all measure indicators improved in comparison with the prior measurement year. However, **HAP Empowered** continues to demonstrate low performance for *Child and Adolescent Well-Care Visits* measure, with the *Ages 3 to 11 Years*, *12 to 17 Years*, and *Total* measure indicators ranking below the 25th percentile, and the *Ages 18 to 21 Years* measure indicator ranking between the 25th and 49th percentile for MY 2022. HSAG therefore recommends that **HAP Empowered** continue its efforts on further improving the *Child and Adolescent Well-Care Visits* rates and monitoring the impact of initiatives currently in place to ensure improved performance. HSAG has determined that **HAP Empowered** addressed the prior year's recommendation for the *Chlamydia Screening in Women—Ages 21 to 24 Years* measure indicator. **HAP Empowered** conducted a root cause analysis to determine why some women were not being screened for breast cancer and implemented initiatives such as hosting women's events to provide needed screening, growing partnerships with providers, and offering member incentives. Additionally, the rate significantly increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **HAP Empowered** addressed the prior year's recommendation for the *Hemoglobin A1c Control for Patients With Diabetes* measure indicators. **HAP Empowered** conducted a root cause analysis to determine why some members with diabetes did not have controlled HbA1c levels and implemented initiatives such as providing in-home HbA1c testing kits to members and partnering with a vendor to provide in-person testing for members. Additionally, the rates significantly increased from the prior measurement year, with the *HbA1c Poor Control (>9.0%)* measure indicator ranking between the 50th and 74th percentile and the

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
HbA1c Control (<8.0%) measure indicator ranking between the 75th and 89th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **HAP Empowered** addressed the prior year's recommendation for the *Eye Exam for Patients With Diabetes* measure indicator. **HAP Empowered** conducted a root cause analysis to determine why some members with diabetes did not have an eye exam performed and implemented initiatives such as partnering with a vendor to provide in-home eye exams for members. Additionally, the rate significantly increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **HAP Empowered** addressed the prior year's recommendation for the *Blood Pressure Control for Patients With Diabetes* measure indicator. **HAP Empowered** conducted a root cause analysis to determine why some members with diabetes did not have controlled blood pressure and implemented initiatives such as partnering with a vendor to provide in-home diabetic services for members. Additionally, the rate significantly increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **HAP Empowered** scored below the statewide average in the Provider standard. The MHP received a *Not Met* score for elements *2.7 Provider Network–MHP Demonstrates that Covered Services are Available and Accessible*, *2.20 Credentialing and Recredentialing Policies*, and *2.21 Secret Shopper Calls*. As **HAP Empowered** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **HAP Empowered** ensure its CAP is fully implemented to mitigate the deficiencies. • **HAP Empowered** scored below the statewide average in the Quality standard. The MHP received a *Not Met* score for element *4.9 PRM*. As **HAP Empowered** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **HAP Empowered** ensure its CAP is fully implemented to mitigate the deficiencies. • **HAP Empowered** scored below the statewide average in the MIS standard. The MHP receive *Not Met* score for elements *5.10 Provider Data Accuracy* and *5.11 Claims Processing (Non-Pharmacy)*. As **HAP Empowered** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **HAP Empowered** ensure its CAP is fully implemented to mitigate the deficiencies. • **HAP Empowered** scored below the statewide average in the Program Integrity standard. The MHP received a *Not Met* score for *6.1 Quarterly Program Integrity Forms–Tips and Grievances* and *6.9 OIG Program Integrity–Compliance Program*. As **HAP Empowered** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **HAP Empowered** ensure its CAP is fully implemented to mitigate the deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
• Related to 4.9 PMR CAP, HAP Empowered implemented an additional review process to include a management level review prior to sending to Compliance for final review and validation. HAP Empowered has also implemented a compliance review checklist, to be completed prior to the management level review to help avoid future non-compliance. Lastly, the PMR Improvement Plan was updated to include the Low-Birth-Weight measure. • Related to the 2.21 Secret Shopper CAP, HAP Empowered has done the following: o Enhanced the monitoring and validation of the provider directory accuracy by conducting mock audits and frequent monitoring. o Enhanced the auditing process to include the procedure, Procedure Monitoring and Validating Provider Directory Accuracy o Invested into our Provider Operations to include a new Director of Network Operations and Vice President of Provider Contracting and Network Development to help strengthening provider relationships and education. o Educate provider office staff through new provider orientation emails, fax, and newsroom on provider portal pertaining to informing Hap Empowered when changes occur. o Contracting and provider services revised welcome letters to include more details online of business participation. • Related to the 2.20 Credentialing and Recredentialing Policies, 5.10 Provider Data Accuracy, and 5.11 Claims Processing (non-pharmacy), and 6.1 Tips and Grievance CAPs, HAP Empowered implemented an internal Compliance Review along with a business owner checklist to ensure that applicable business owners were following MDHHS requirements. o The Compliance level review includes email reminders of submission deadlines along with verification of the information provided in the report submitted by the business owner. o For the 6.1 Tips and Grievance report, the Compliance level review includes reviewing previous Program Integrity submissions to ensure if there are any carryover cases, that they are added to the new report. • Related to the 6.9 OIG Program Integrity CAP, HAP Empowered's SIU Compliance team has done the following: o Worked with human resources to improve the Exit Interview to include Compliance-related questions. • Related to the 2.7 Network Access Plan (NAP) CAP, HAP Empowered, reformatted the document to help with ease of question alignment and make finding answers more identifiable.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Related to 4.9 PMR, HAP Empowered implemented the improvements noted above and submitted section 4.9 during the July 2023 compliance review and received a Met status. • Related to the 2.2, 5.10, 5.11 and 6.1 CAPS, HAP Empowered has received Met statuses for the FY23 Compliance Review year in those sections and previous CAP reasons. • Related to the 6.9 CAP since the Exit Interview has been updated, HAP Empowered received a Met status. • Related to the 2.7 CAP, HAP Empowered's document update resulted in a MET status for FY23.
c. Identify any barriers to implementing initiatives: • Related to the 2.21 CAP, the barrier is lack of notification from a provider when changes occur to include staffing and address changes.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG Assessment: HSAG has determined that **HAP Empowered** addressed the prior year's recommendation. The SFY 2023 compliance review activity confirmed that **HAP Empowered** received a *Met* score for elements 2.7, 2.20, 4.9, 5.10, 5.11, and 6.9. However, while **HAP Empowered** implemented initiatives to address the deficiencies for elements 2.21 and 6.1, these initiatives do not appear to have been fully successful as the MHP continued to receive a *Not Met* score for elements 2.21 and 6.1 during the SFY 2023 compliance review activity. As such, HSAG recommends that **HAP Empowered** continue to explore opportunities to enhance the accuracy of its provider data and online provider directory, and data reported to MDHHS via the program integrity forms.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • Only 70.2 percent of the sampled provider locations could be reached. In addition to the limitations related to the secret shopper approach, **HAP Empowered**'s provider data included invalid telephone or address information when contacting the office staff members. HSAG recommends that **HAP Empowered** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies. • Of cases in which the survey respondent reported that the provider location accepted **HAP Empowered**, Medicaid, and new patients, only 79.4 percent of cases offered the caller an appointment date. OB/GYN provider locations had an appointment availability rate of 56 percent. For new **HAP Empowered** members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. HSAG recommends that **HAP Empowered** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **HAP Empowered** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • HAP Empowered has enhanced the monitoring and validation of the provider directory accuracy by conducting mock audits and frequent monitoring. • HAP Empowered has enhanced the auditing process to include the procedure, Procedure Monitoring and Validating Provider Directory Accuracy. HAP Empowered has invested into our Provider Operations to include a new Director of Network Operations and Vice President of Provider Contracting and Network Development to help strengthening provider relationships and education. • Educate provider office staff through new provider orientation emails, fax, and newsroom on provider portal pertaining to informing Hap Empowered when changes occur. • Contracting and provider services revised welcome letters to include more details online of business participation.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HAP Empowered reached out to a sample of providers who did not meet appointment availability standards and educated them on the appropriate standards and the importance of having available appointments for HAP Empowered members. Since providers expressed significant concerns on resources in their offices to be able to offer additional appointment times, HAP Empowered focused efforts on expanding the number of available providers in the HAP Empowered network. Over the past year, HAP has dedicated significant efforts to expanding the provider network by opening contract negotiations with all large health systems in Michigan to contract with HAP for Medicaid services and reaching out to non-contracted providers who are not affiliated with a health system to contract with HAP Empowered. These efforts have resulted in growth of the provider network in many provider specialties.
c. Identify any barriers to implementing initiatives: • HAP Empowered's biggest barrier is lack of notification when provider changes occur to include staffing and address changes.
HSAG Assessment: HSAG has determined that **HAP Empowered** addressed the prior year's recommendation, as noted through its monitoring and validation efforts. However, the MHP should continue these efforts to ensure members have accurate information available to make appointments and to ensure any barriers to accessing care are mitigated.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG recommended the following: **Adult and Child Medicaid** • HSAG recommends that **HAP Empowered** monitor the measures to ensure significant decreases in scores over time do not occur. **CSHCS** • HSAG recommends that **HAP Empowered** monitor the measures to ensure significant decreases in scores over time do not occur. **HMP** • **HAP Empowered**'s 2022 top-box scores were statistically significantly lower than the 2021 NCQA adult Medicaid national averages for two measures: *Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Strategies*. When compared to national benchmarks, the results indicate that **HAP Empowered**'s providers may not be advising members who smoke or use tobacco to quit or discuss cessation strategies as often as other providers. HSAG recommends that **HAP Empowered** explore drivers of lower experience scores and continue to develop initiatives designed to improve quality of care, including a focus on improving the provision of medical assistance with smoking and tobacco use cessation to members and reducing barriers to engagement. **HAP Empowered** should provide training and resources to providers to promote smoking cessation with their members.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
• HAP Empowered reviews performance each year against prior year and national average for quality compass to determine whether any metrics that are deficient and high impact to member satisfaction with health plan.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • HAP is partnering with CareSource to increase the Tobacco Cessation referral process. CareSource will provide education to all clinical staff during orientation and will reinforce the importance of tobacco cessation at internal meetings. CareSource has developed talking points for staff to assist in the discussion of QuitLine and has the information located on member and provider websites, and within the member handbook. • For members who select tobacco cessation as healthy behavior on HRA, they will receive letter with information concerning benefits and QuitLine. CHWs will make up to three attempts to contact these members to educate and connect with QuitLine. The CHW will follow members x 3 months to provide support.
c. Identify any barriers to implementing initiatives: • Low response rates to the CAHPS surveys (7.33% for MY 2021) reduce the reportable responses, which impacts the performance review and ability to identify member issues, needs, and to develop initiatives.
HSAG Assessment: HSAG has determined that **HAP Empowered** has addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **HAP Empowered**'s scores for *Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Strategies* for the adult Medicaid population were comparable to 2022 NCQA adult Medicaid national averages. The score for *How Well Doctors Communicate* was statistically significantly higher than the 2022 NCQA adult Medicaid national average for the HMP population. Furthermore, scores were comparable to national averages and the 2022 top-box scores for all measures for the adult and child Medicaid, CSHCS, and HMP populations.

McLaren Health Plan

Table 4-4—Prior Year Recommendations and Responses for MCL

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although there were no identified weaknesses, HSAG recommends **McLaren Health Plan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For FY2023, McLaren Health Plan interventions continue to be underway aimed at educating and incentivizing members and providers for completing timely prenatal and postnatal care, implementing targeted outreach to members via a comprehensive texting campaign with focus in highest disparate areas, collaboration with our CHW partners and continuing to provide routine care gap reports to providers with disparity information. McLaren Health Plan monitors outcomes monthly to identify trends that may require the development of new interventions. No new barriers identified. • For FY2023, McLaren Health Plan did not note any new barriers for Asthma Medication Ratio (AMR). Interventional efforts continue with education to providers including coding and gap reports, monthly Quality Quick Tips (QQTs), and coordination with a CHW organization which initiated a comprehensive program specific to asthma identification, environmental abatement, exacerbation prevention and treatment.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Postpartum Care (PPC2) did note an 8.56% increase in timely post-partum care.
c. Identify any barriers to implementing initiatives: • Barriers identified include a decrease in reaching and achieving a successful call to members and a subsequent decrease in CHW referrals. McLaren implemented a member facing text messaging campaign surrounding receipt of timely prenatal and postnatal care. Text messaging has a higher rate of engagement than traditional phone calls. • Barriers for Asthma remain the same. Our focus continues educating providers and members on the prevention of asthma exacerbation and ensuring timely medication adherence via Newsletters, monthly QQT's, member mailings, reporting gaps on the portal for members and providers.
HSAG Assessment: HSAG has determined that **McLaren Health Plan** addressed the prior year's recommendation. The MHP revisited its causal/barrier analysis and concluded that no new barriers to care exist for the prenatal care PIP topic.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **McLaren Health Plan**'s performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
always getting at least two well-child visits with a PCP in the last 15 months. HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. • **McLaren Health Plan**'s performance for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators ranked below the 25th percentile, indicating that members with diabetes did not aways have controlled HbA1c levels. HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled HbA1c levels. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators. • **McLaren Health Plan**'s performance for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked below the 25th percentile, indicating some members with diabetes did not have controlled blood pressure. HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled blood pressure. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator. • **McLaren Health Plan**'s performance for the *Controlling High Blood Pressure* measure ranked below the 25th percentile, indicating that some members with a diagnosis of hypertension did not have controlled blood pressure. HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with hypertension did not have controlled blood pressure. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Controlling High Blood Pressure* measure. • **McLaren Health Plan**'s performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Ages 18 to 21 Years* measure indicators ranked between the 25th percentile and 49th percentile, indicating some children were not always receiving one or more well-care visit during the measurement year. HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits* measure. • **McLaren Health Plan**'s performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for cervical cancer. HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure. • **McLaren Health Plan**'s performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure. • **McLaren Health Plan**'s performance for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have an eye exam to screen or monitor for diabetic retinal disease. HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have an eye exam performed. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator. • **McLaren Health Plan**'s performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure indicators ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. HSAG recommends that **McLaren Health Plan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **McLaren Health Plan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • McLaren Health Plan continues to closely monitor performance monthly for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure throughout the year. Providers continue to be given monthly gap reports that indicate what members need specific services as well as information on incentives for child health services including well child visits. McLaren also partnered with a vendor to implement a comprehensive texting campaign at the member level to gently educate on the importance of preventative services, what services they are due for and identify resources to help overcome barriers to accessing care. Member feedback indicates that provider offices will prevent timely scheduling because they are under the false belief that well child visits must be a complete year from previous well visit as opposed to within the next calendar year; provider education is geared to correct this false assumption. In addition to the above, McLaren continues to collaborate with our Community Health Worker (CHW) organizations to conduct outreach to members. Our CHWs can assess barriers that may be impacting their access to care and connect them with resources. These CHWs are now billing those Social Determinants of Health (SDoH) diagnosis codes along with their services so McLaren can further analyze the data to determine additional barriers within the populations and look for interventions to address them. McLaren also implemented Find Help, so that members, CHW's and Nurse Case Managers can utilize it to find resources for a variety of needs from housing, clothes, food, financial assistance, etc. Continual assessment of the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rates will occur to ensure additional interventions are implemented as needed and any barriers addressed. • McLaren closely monitors the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure monthly and reviews a Year Over Year (YOY) comparison for Health Equity on McLaren's HEDIS dashboards. When looking at A1C control between white, black

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
and other races, McLaren acknowledges a 10+% disparity between white HbA1C control and other races/ethnicities. McLaren routinely provides providers with monthly care gap reports outlining members who evidence poor glycemic control (A1C >9%), sends Quality Quick Tips (QQT's) on diabetes control, and incorporates education on this measure on the revised McLaren Health Plan website for providers. In addition, McLaren also partners with our CHW partners to provide outreach to members, especially in regions of our desperate members to assess for barriers that may be impacting their access to care and help connect them to resources. McLaren also is seeking state approval for a new comprehensive texting campaign with our texting vendor that will help gently educate members on the importance of good diabetes control and what diabetic screenings/tests that they are due for as well as help provide links to resources to help overcome barriers in accessing care. McLaren also continues to offer incentives to members ($25.00 for HbA1C test and additional $5.00 for A1C <8). We are hopeful that a more focused partnership with the National Kidney Foundation of Michigan (NKFM) and the Michigan Diabetes Prevention Program (DPP) will help members overcome barriers to health and optimize diabetes control. • McLaren closely monitors the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure. While BP is typically measured in most provider encounters, a second reading is considered best practice but often missed if a first BP is >140/90. In addition to routinely providing providers with their monthly care gap reports outlining their diabetic members with Blood Pressure (BP) >140/90, providers are also sent QQT's on Diabetes care including Blood Pressure management, the importance of obtaining a second BP reading of the first was >140/90, reminders about member incentives for accessing diabetes care as well as access to additional provider resources on this and other disease management topic areas on the newly revised McLaren Health Plan website. In addition to providing member incentives and outreach via our CHW partnerships to help address gaps in care and barriers to care, McLaren will be also implementing a new comprehensive texting campaign with focus on gently educating members on all aspects of diabetes management, identifying gaps in care needs and providing links to resources to help overcome barriers in accessing care needs. We are hopeful that a more focused partnership with the National Kidney Foundation of Michigan (NKFM) and the Michigan Diabetes Prevention Program (DPP) will help members overcome barriers to health and optimize diabetes control. • *Controlling High Blood Pressure* measure is also closely monitored monthly by McLaren Health Plan. While BP is typically measured in most provider encounters, a second reading is considered best practice but often missed if a first BP is >140/90. In addition to routinely providing providers with their monthly care gap reports outlining their members with BP >140.90 or no BP on record for the measurement year. McLaren continues to provide education on the importance of capturing a second measurement in addition to other aspects of hypertensive management in Member Newsletters, Provider Newsletters, monthly QQT's, and gap reports showing non-compliant members. McLaren also partners with its CHW partners to help identify members who have BP >140/90 or haven't been seen within the measurement year and connect those members to a medical provider who have none or address SDOH barriers to accessing care. • McLaren monitors its performance for *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Ages 18 to 21 Years* measure monthly. In addition to providing provider partners with their care gap reports, McLaren addresses probable causes of gaps by providing education to providers on the proper coding important to capturing and recording the components of the care that they are providing (i.e. sports physicals and well child exams). In addition, member feedback indicates that provider offices will prevent timely scheduling because they are under the false belief that well child visits must

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures

be a complete year from previous well visit as opposed to within the next calendar year; provider education is geared to correct this false assumption.

- The *Cervical Cancer Screening* measure is also closely monitored monthly and YOY comparison for Health Equity on McLaren's HEDIS dashboards. When comparing year to year Cervical Cancer Screening (CCS) between whites, black and other races, we don't see significant disparity between race/ethnicity in this measure. When looking at probable root cause, a barrier to tracking historical CCS data can be entertained especially with members who are switching plans or providers, and ensuring proper documentation regarding exclusions to this measure are documented. Interventional efforts are therefore geared to ensuring that providers have reports on member gaps in recommended services and members are educated on the importance of preventative screenings. Interventions are focused on educating members via the Women's section of the Member Newsletter and the Women's Health letter mailing identifying needed services. Providers are educated via Monthly QQT's, Gap reports, HEDIS Report cards. This measure is also addressed in McLaren's texting campaign focused on addressing all women's health care needs including Cervical Cancer Screening as well as with our CHW partners who work of lists provided by McLaren to do outreach to members who are missing key preventative services and help address any barriers to accessing services.
- McLaren's *Breast Cancer Screening* measure is also tracked and closely monitored monthly as well as YOY for Health Equity on its HEDIS dashboards. No significant disparity is seen between race/ethnicity for this measure and interventions are focused on addressing member and provider reminders and education. As with Cervical Cancer measure, providers are given care gap reports monthly on members who are missing recommended services and also incentivized with $50.00 per mammogram completed. This measure is also addressed in McLaren's texting campaign focused on addressing all women's health care needs including Breast Cancer Screening as well as with our CHW partners who work of lists provided by McLaren to do outreach to members who are missing key preventative services and help address any barriers to accessing services. Members are also incentivized with a $20.00 gift card for mammogram completion and a chance to win an iPad in a quarterly drawing.
- The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure is tracked and monitored monthly on McLaren's HEDIS dashboard. Probable root cause analysis points to records management on the provider level and the fact that members often have to have this test done in a different provider office (Ophthalmology) and results not always shared with the referring provider or primary care provider (PCP). As with other diabetes care measures, the Diabetes Eye Exam care gap report is provided monthly to providers to do follow up with their patients. Providers are also sent QQT's on Diabetes care including Diabetic Eye Exams and member incentives for accessing diabetes care as well as access to additional provider resources on this and other disease management topic areas on the newly revised McLaren Health Plan website. In addition to member outreach via our CHW partnerships to help address gaps in care and barriers to care, McLaren will be also implementing a new comprehensive texting campaign with focus on gently educating members on all aspects of diabetes management, identifying gaps in care needs and providing links to resources to help overcome barriers in accessing care needs.
- The *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure is also tracked monthly on McLaren's HEDIS dashboard. As with other diabetes care measures, the Kidney Health Evaluation for Patients with Diabetes care gap report is provided monthly to providers to do follow up with their patients. Providers are also sent QQT's on Diabetes care including Diabetic Kidney testing and member incentives for accessing diabetes care as well as access to additional provider resources on this and other disease management topic areas on the newly revised McLaren

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
Health Plan website. In addition to member outreach via our CHW partnerships to help address gaps in care and barriers to care, McLaren will be also implementing a new comprehensive texting campaign with focus on gently educating members on all aspects of diabetes management, identifying gaps in care needs and providing links to resources to help overcome barriers in accessing care needs. We are hopeful that a more focused partnership with the National Kidney Foundation of Michigan (NKFM) and the Michigan Diabetes Prevention Program (DPP) will help members overcome barriers to health and optimize diabetes control. Barriers to this measure include confusion in appropriate provider testing to include both the Glomular Filtration Ratio (eGFR) and Urine Albumin/Creatinine Ratio given the fact that less than 50% of people with diabetes receive both screenings; education to providers includes this information. For patients, education on kidney disease testing as it has been shown that nine out of ten patients do not know that they are unaware of having a diagnosis of Chronic Kidney Disease (CKD). • For all measures with exception of the KED measure, McLaren is inputting supplemental data not only through charts shared by provider offices, but via direct electronic medical record (EMR) access allowing more continual auditing of gap closures.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months*—Two or More Well-Child Visits noted an upward trend from 59% in MY2021 to 62% in MY2022. McLaren will continue to monitor and implement interventions as needed. • *Comprehensive Diabetes Care—Blood Pressure Control* (<140/90 mm Hg) measure noted an upward trend from 43% in MY2021 to 48% in MY2022. McLaren will continue to monitor and implement interventions as needed. • *Controlling High Blood Pressure* measure noted a trend upward from 45% in MY2021 to 47% in MY2022. McLaren will continue to monitor and implement interventions as needed. • McLaren's performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Ages 18 to 21 Years* measure showed a positive trend up for both ages 12-17 and 18-21 in 2022. Ages 12-17 went from 42% in MY2021 to 47% in MY2022 and ages 18-21 went from 22% in MY2021 to 23% in MY2022. McLaren will continue to monitor and implement interventions as needed. • *Breast Cancer Screening* measure improved slightly from 54% in MY2021 to 55% in MY2022. McLaren will continue to monitor and implement interventions as needed. • *The Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure improved from 51% in MY2021 to 53% in MY 2022. McLaren will continue to monitor and implement interventions as needed. • *The Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure improved slightly from MY 2021 (29%) to MY 2022 (31%). McLaren will continue to monitor and implement interventions as needed.
c. Identify any barriers to implementing initiatives: • Barriers identified in the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure include provider coding inconsistencies found in ordering and coding the kidney tests that correctly align with this measure. Considering that *literature tells us that 50% of people with diabetes receive both screenings, there seems to be provider confusion to include both the Glomular Filtration Ratio (eGFR) and Urine Albumin/Creatinine Ratio and which code to use (CPT 82043 versus CPT 82044); education to providers includes this information. For patients, education on kidney disease testing will be included as literature has shown that nine out of ten patients do not know that they are at risk of kidney disease.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
**National Kidney Foundation of Michigan* • Barriers noted for all measures where outreach is attempted due to inappropriate phone numbers or missing phone numbers for members which limits our ability to outreach via texts or calls. Similarly, barriers are also encountered with invalid addresses when attempting member outreach via mailings.
HSAG Assessment: HSAG has determined that **McLaren Health Plan** has partially addressed the prior year's recommendations. **McLaren Health Plan** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator by giving providers monthly gap reports that indicated members needing specific services and information on incentives for child health services, partnering with a vendor to implement a comprehensive texting campaign, partnering with CHWs to conduct member outreach, providing member education on the importance of preventative services, sending reminders for services due, and identifying resources to help overcome barriers to accessing care. While the measure indicator rate significantly increased from the prior measurement year, **McLaren Health Plan** continues to demonstrate low performance for the measure indicator, with the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator ranking between the 25th and 49th percentile for MY 2022. HSAG recommends continued efforts by **McLaren Health Plan** to further improve performance for the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator and monitoring of initiatives currently in place to ensure continued improved performance. Regarding HSAG's prior year recommendation for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators, **McLaren Health Plan** has demonstrated efforts by giving providers monthly care gap reports outlining members with poor HbA1c control, partnering with CHWs to outreach to members, providing member incentives, and providing education to members and providers. However, **McLaren Health Plan** continues to demonstrate low performance for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators by ranking below the 25th percentile for MY 2022. HSAG therefore recommends that **McLaren Health Plan** continue its efforts on further improving the *Hemoglobin A1c Control for Patients With Diabetes* rates and monitoring the impact of initiatives currently in place to ensure improved performance. Pertaining to HSAG's prior year recommendation for the *Blood Pressure Control for Patients With Diabetes* measure, **McLaren Health Plan** has demonstrated efforts by distributing care gap reports to providers to outline members with blood pressure readings greater than 140/90, providing education to providers, giving member incentives, and partnering with CHWs to outreach to members. While the measure rate increased from the prior year, **McLaren Health Plan** continues to demonstrate low performance for the *Blood Pressure Control for Patients With Diabetes* measure by ranking below the 25th percentile for MY 2022. HSAG therefore recommends that **McLaren Health Plan** continue its efforts on further improving the *Blood Pressure Control for Patients With Diabetes* rate and monitoring the impact of initiatives currently in place to ensure improved performance. Regarding HSAG's prior year recommendation for the *Controlling High Blood Pressure* measure, **McLaren Health Plan** has demonstrated efforts by distributing care gap reports to providers to outline members with blood pressure readings greater than 140/90, providing routine provider reminders, and conducting member outreach through CHW partnerships. While the measure rate increased from the prior year, **McLaren Health Plan** continues to demonstrate low performance for the *Controlling High Blood Pressure* measure by ranking below the 25th percentile for MY 2022. HSAG therefore recommends that **McLaren Health Plan** continue its

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
efforts on further improving the *Controlling High Blood Pressure* rate and monitoring the impact of initiatives currently in place to ensure improved performance. Pertaining to HSAG's prior year recommendation for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Ages 18 to 21 Years* measure indicators, **McLaren Health Plan** has demonstrated efforts by providing education to providers on topics such as proper coding and the importance of capturing the components of the care that they are providing (i.e., sports physicals and well-child exams). However, **McLaren Health Plan** continues to demonstrate low performance for the *Child and Adolescent Well-Care Visits—Ages 12 to 17 Years* and *Ages 18 to 21 Years* measure indicators by ranking between the 25th and 49th percentile for MY 2022. HSAG therefore recommends that **McLaren Health Plan** continue its efforts on further improving the *Child and Adolescent Well-Care Visits* rates and monitoring the impact of initiatives currently in place to ensure improved performance. Regarding HSAG's prior year recommendation for the *Cervical Cancer Screening* measure, **McLaren Health Plan** has demonstrated efforts by providing reports to providers on member gaps in recommended services, providing member education on the importance of preventative screenings, educating providers, and conducting texting campaigns. However, **McLaren Health Plan** continues to demonstrate low performance for the *Cervical Cancer Screening* measure by ranking between the 25th and 49th percentile. HSAG therefore recommends that **McLaren Health Plan** continue its efforts on further improving the *Cervical Cancer Screening* measure rate and monitoring of the impact of initiatives currently in place to ensure improved performance. **McLaren Health Plan** could consider the development and deployment of a digital notification system for members needing cervical cancer screening and incorporating screening reminders into current care coordination member touchpoints. HSAG has determined that **McLaren Health Plan** addressed the prior year's recommendation for the *Breast Cancer Screening* measure. **McLaren Health Plan** conducted a root cause analysis to determine why some women were not being screened for breast cancer and implemented initiatives such as providing reports to providers on member gaps in recommended services, giving member incentives, and conducting texting campaigns. Additionally, the rate increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **McLaren Health Plan** addressed the prior year's recommendation for the *Eye Exam for Patients With Diabetes* measure. **McLaren Health Plan** conducted a root cause analysis to determine why some members with diabetes did not have an eye exam to screen or monitor for diabetic retinal disease and implemented initiatives such as providing reports to providers on member gaps in recommended services and conducting member outreach through its partnerships with CHWs. Additionally, the rate increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. Pertaining to HSAG's prior year recommendation for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* measure indicators, **McLaren Health Plan** has demonstrated efforts by providing education to providers, distributing care gap reports to providers, offering member incentives, partnering with CHWs to address member access to care barriers, and implementing a new texting campaign to assist members with gaps in care and obtaining needed resources. While the measure rates increased from the prior year, **McLaren Health Plan** continues to demonstrate low performance for the *Kidney Health Evaluation*

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
for Patients With Diabetes—Ages 18 to 64 Years and *Total* measure indicators by ranking between the 25th and 49th percentile. HSAG therefore recommends that **McLaren Health Plan** continue its efforts on further improving the *Kidney Health Evaluation for Patients With Diabetes* measure rates and monitoring of the impact of initiatives currently in place to ensure improved performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **McLaren Health Plan** scored below the statewide average in the Administrative standard. The MHP received a *Not Met* score for elements *1.1 Organizational Chart* and *1.2 Administrative Position Descriptions*. As MDHHS previously informed **McLaren Health Plan** that, in future compliance reviews, the MHP must follow through with the expectations of elements *1.1 Organizational Chart* and *1.2 Administrative Position Descriptions* and have the proper credential review of positions that have training, education, certification, and licensure requirements, HSAG recommends **McLaren Health Plan** implement action plans to ensure it mitigates the deficiencies in future submissions to MDHHS.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • No action plan was initiated as the deficiency was related to timing in notification to MDHHS related to staff hiring and effective date in position. Non-compliance was noted related to the multiple staff hirings for the same position and when they became effective on our plan. Corrective Action Plan was not requested by MDHHS related to non-compliance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • FY23 McLaren Health Plan demonstrated compliance with 1.1 Organizational Chart and 1.2 Administrative Position Descriptions.
c. Identify any barriers to implementing initiatives: • No barriers to implementation have been identified.
HSAG Assessment: HSAG has determined that **McLaren Health Plan** addressed the prior year's recommendation. The SFY 2023 compliance review activity confirmed that **McLaren Health Plan** received a *Met* score for elements 1.1 and 1.2.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • Only 71.0 percent of the sampled provider locations could be reached. In addition to the limitations related to the secret shopper approach, **McLaren Health Plan**'s provider data included invalid telephone or address information when contacting the office staff members. HSAG recommends that **McLaren Health Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies. • Of cases reached, only 77.1 percent indicated the office provided the specialty services requested, and of these only 73.8 percent indicated the sampled provider was affiliated with the location. **McLaren Health Plan**'s provider data included invalid specialty and provider information. HSAG recommends that **McLaren Health Plan** use the case-level analytic data files containing provider deficiencies identified

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
during the survey (e.g., records with incorrect specialty or provider information) to address the provider data deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

Provider Relations is made aware of provider data conflicts through several different methods. When conflicts arise, they're added to an adds/changes/terms spreadsheet and records are updated according to department procedures. To address identified provider deficiencies, McLaren Health Plan also reviewed case-level data files and took the following actions:

- Updated McLaren Health Plan Provider Relations process and procedure: *Audit of Provider Data Changes and Identification of Opportunities*
  - This revised process combines two other similar processes Provider Relations put in place for 2022.
- Data decision tree and quarterly provider data attestation
  - McLaren Health Plan seeks to obtain attestations from providers at every opportunity and utilizes a three-tiered data attestation and roster validation process to obtain the most up-to-date provider information, including supplemental resources such as the Council for Affordable Quality Healthcare (CAQH) and Google.
  - In 2022, McLaren Health Plan developed and implemented attestation functionality within our secure online provider portal to collect provider demographic changes. A provider bulletin was distributed informing providers of a requirement to attest to their demographic information quarterly. (See Attestation Decision Tree Flowsheet.)
- Implementation of Quest Analytics (BetterDoctor) in 2023 to capture more validations from providers via mail/telephonic/fax outreach McLaren Health Plan also partnered with Quest Analytics (BetterDoctor) in 2023 to capture validations (attestations) from providers via mail/telephonic/fax outreach on our behalf.
  - Originally scheduled to begin Q3 2023, McLaren Health Plan implemented BetterDoctor in Q2. The team finished preparations early and outreach to MHP providers began June 1, 2023. Internal Provider Relations staff were trained on the process and how to access the Quest portal on 5/23/23. A provider bulletin was distributed reminding providers of their requirement to attest quarterly to their demographic information and that BetterDoctor would be contacting their office on McLaren Health Plan's behalf. As McLaren Health Plan develops the relationship with BetterDoctor on the quarterly attestation process, we expect to have quarterly reporting indicating # of providers attested, and # of changes updated in the MIS, this will continue to evolve.
  - Provider Servicing occurs during regularly scheduled Provider Rounding meetings and ad-hoc sessions. High volume PCPs receive rounding quarterly, PCPs with less than 50 members receive rounding at least annually. During rounding, PCP information is validated, including but not limited to address, phone, fax, email, and acceptance status verification. PO/PHOs [physician's offices/physician hospital organizations] are required to provide monthly rosters to verify/validate provider information. When changes are identified, they are submitted to the MIS and flow to the provider directory.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
○ In situations where a provider's front office staff states they aren't accepting new patients or are unaware of the provider's participation status with McLaren Health Plan, the Provider Relations Representative immediately contacts the provider's office manager to validate the information and remedy any discrepancies. The Provider Relations Representative also takes the time to educate the office manager on the requirements for opening and closing a practice, as outlined in the Provider Manual, and the provider incentives applicable to having an open practice. ○ If McLaren Health Plan receives a member complaint regarding a provider directory discrepancy, it is handled immediately. At a minimum, this requires telephonic outreach to a provider's office to assist the member in getting care, educating offices on participation status and the quarterly attestation requirement, and follow up to ensure the provider's office is adhering to their participation contract. In addition, quarterly analysis of member complaints is reviewed to identify any opportunities for improvement. For the time frame of June 2022 – June 2023, there were no member complaints regarding a provider directory discrepancy. ○ In cases where there's a change in location, or a provider is no longer at the office; the Provider Relations Representative requests the appropriate documentation for the contract file and makes the system change to accurately reflect the provider's status. ○ Provider Bulletins provide updates and reminders to providers regarding important plan initiatives, changes, and updates - including quarterly attestation. • Implementation of Salesforce for provider data ○ McLaren Health Plan is actively implementing a Salesforce system for Provider Data Management by end Q1 2024 which will function as the only source of truth for provider data within the organization. Moving to Salesforce is expected to reduce data loss and errors, manual data entry and increase provider's self-service capability. ○ Upon implementation of Salesforce, McLaren Health Plan expects most provider data audit processes will require modification (including those identified above) and revisions to existing processes will need to be modified and enhanced. Salesforce is expected to streamline McLaren Health Plan provider data and improve efficiencies across all platforms and business areas. Salesforce will fundamentally improve how McLaren Health Plan enters, monitors, audits, and extracts provider data – including changes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As McLaren Health Plan moves to full implementation of Salesforce, McLaren Health Plan expects to realize marked improvement to management processes for and accuracy monitoring of our online Provider Directories. Salesforce will consolidate McLaren Health Plan provider data into one location and become the single source of truth, making it easier to access, retrieve and review provider information in full. The current provider directory process is compliant with Medicaid requirements. McLaren Health Plan expects to develop and publish provider directories exceeding timeframes required by MDHHS within 6 months of the Salesforce full implementation go-live date.
c. Identify any barriers to implementing initiatives: • Although MCL updated its *Audit of Provider Data Changes and Identification of Opportunities* process and procedure, resource constraints negatively impacted the organization's ability to fully implement. The MCL Provider Relations department experienced multiple staff transitions throughout the last half of 2022, ultimately impacting operational functions at both the staff and leadership levels. As a result, Provider Relations reallocated staffing resources in 2023 and 2024 to perform essential functions and train new staff on the updated process as quickly as possible.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
• Salesforce was initially set to launch in the first quarter of 2023. However, due to unforeseen complexities in the initial roadmap and the multiple data sources required to deliver a robust, multifunctional provider management system, the go-live date was delayed to accommodate development of necessary system functions. A soft-launch of Salesforce occurred in late August 2023 with full implementation to production set to occur during the first quarter of 2024. Internal implementation of work streams, testing and validation were initiated and are ongoing.
HSAG Assessment: HSAG has determined that **McLaren Health Plan** addressed the prior year's recommendation, as noted through its monitoring and validation efforts, amongst other initiatives. However, the MHP should continue these efforts to ensure members have accurate information available to make appointments and to ensure any barriers to accessing care are mitigated.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG recommended the following: **Adult and Child Medicaid** • **McLaren Health Plan**'s 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Rating of Health Plan*. When compared to national benchmarks, the results indicate that parents/caretakers of child members enrolled in **McLaren Health Plan** had less positive overall experiences with their child's health plan, since the score for this measure was statistically significantly lower than the 2021 NCQA child Medicaid national average. HSAG recommends that **McLaren Health Plan** continue to explore what may be driving lower experience scores and develop initiatives designed to improve quality of care. HSAG further recommends the MHP continue to explore the option of conducting other MHP-specific member experience surveys that allow the MHP to impact negative member-specific experiences. **CSHCS** • HSAG recommends that **McLaren Health Plan** monitor the measures to ensure significant decreases in scores over time do not occur. **HMP** • **McLaren Health Plan**'s 2021 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, *Rating of Specialist Seen Most Often*. When compared to national benchmarks, the results indicate that **McLaren Health Plan**'s members are reporting a more negative experience with their specialist. HSAG recommends that **McLaren Health Plan** determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the plan that could be contributing to a lack of network adequacy and access issues. HSAG further recommends the MHP continue to explore the option of conducting other MHP-specific member experience surveys that allow the MHP to impact negative member-specific experiences.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For 2023, McLaren Health Plan noted a positive trend in the Child Medicaid measure *Rating of Health Plan*; scoring 71.43% which is improved from scores in 2021 (65.33%) and 2022 (62.74%) indicating a more positive overall experience with their health plan. Activities implemented in 2022-23 include the

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
implementation of a comprehensive texting campaign designed to help educate members on the importance of routine preventative care needs as well as helping to connect members to needed resources. This proactive approach was seen not only as educational, but also serves to communicate to members that McLaren Health Plan is accessible and has a variety of resources to help its members. • McLaren will continue to track CSHCS measures to monitor scores over time. • For the 2022 Healthy Michigan Plan Measure *Rating of Specialist Seen Most Often* (2023 results are unavailable), McLaren Health Plan saw a decrease of 8 percentage points in 2022 compared to 2021. Access to specialties can by limited in more rural areas, especially troublesome in combination with barriers linked to social determinants of health (time away from work, childcare, transportation, costs) to access those services. Activities are underway to assess the adequacy by region of contracted specialist by specialty, use of Community Health Worker Partners to help overcome barriers and connect services to disparate members and review other key measures that correlate to ratings of specialist such as *How Well Doctors Communicate, Getting Care Quickly, Coordination of Care and Getting Needed Care.*
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The 2023 Child Medicaid measure Rating of Health Plan; scoring was 71.43% which is improved from scores in 2021 (65.33%) and 2022 (62.74%) respectively.
c. Identify any barriers to implementing initiatives: Barriers to the Child Medicaid measure of Rating of Health Plan include: • A historically low response rate; especially to child Medicaid CAHPS. Barriers to implementing initiatives for Adult Medicaid measure of Rating of Specialist include: • Rural areas have more shortages of specialists than the more urban regions of Michigan, causing hardships on members who have transportation barriers to access specialists outside of their community.
HSAG Assessment: HSAG has determined that **McLaren Health Plan** has partially addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **McLaren Health Plan**'s score for *Rating of Health Plan* for the child Medicaid population was comparable to the national average; however, **McLaren Health Plan**'s score for *Rating of All Health Care* for the child Medicaid population was statistically significantly lower than the 2022 NCQA child Medicaid national average and 2022 top-box score. Furthermore, **McLaren Health Plan**'s score for *Rating of Specialist Seen Most Often* for the HMP population was comparable to the national average; however, **McLaren Health Plan**'s score for *Rating of Personal Doctor* for the HMP population was statistically significantly lower than the 2022 NCQA adult Medicaid national average and the 2022 top-box score. **McLaren Health Plan** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **McLaren Health Plan** continue to implement performance improvement interventions and evaluate their effectiveness.

Meridian Health Plan of Michigan

Table 4-5—Prior Year Recommendations and Responses for MER

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although there were no identified weaknesses, HSAG recommends **Meridian Health Plan of Michigan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Providers are incentivized for successful completion of HEDIS Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care measure. • Meridian publishes HEDIS PPC care gap reports to alert providers of any assigned members due for a timely prenatal care visit. • Meridian publishes a HEDIS Quick Reference Guide (QRG) as an educational tool to ensure providers understand HEDIS PPC measure compliance requirements. • HEDIS PPC Timeliness of Prenatal Care telephonic outreach campaigns engage members to provide education and assist with timely prenatal care appointment and transportation scheduling. • Meridian's Community Health Workers (CHW) engage Region 6 PIP members for barrier assessment, care, and resource coordination services. • African American members are incentivized for successful completion of timely prenatal care visits. • Meridian incentivizes HEDIS PPC measure members for successful completion of a Notification of Pregnancy assessment and timely prenatal care visits. • Start Smart for Baby maternity case management program (SSFB) provides prenatal care and SDoH assessments, maternity education, care and resource coordination services to HEDIS PPC measure members. Case Managers support and facilitate connection to appropriate care. • Meridian sends bi-monthly member referral lists to the Genesee County CHW delegate, Greater Flint Health Coalition (GFHC) for engagement, education, barrier assessment, care and resource coordination services to ensure timely prenatal care visit completion. Genesee county has the greatest racial disparity for PPC Timeliness of Care of all PIP counties. • In July 2023, Meridian implemented a Maternal Health Equity Pod- Pilot program in two of the PIP counties, Tuscola and Genesee. Meridian's Maternal Health Equity Pod is an integrative service delivery model designed to provide a seamless and comprehensive experience for pregnant members in targeted counties. Historical, claims, prenatal screenings, behavioral health, and Social Determinants of Health (SDoH) assessment data are used to stratify and provide specialized care and resource coordination services. Each pod has readily available access to a service coordinator, clinical complex case manager (RN), a Community Health Outreach Worker, behavioral health specialist, Medical Director, and doulas are incorporated into each birthing plan. Since the inception, 20 members in Tuscola county and 27 members in Flint have been enrolled.

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Meridian's CHW delegate intervention with Greater Flint Health Coalition (GFHC) has been successful in reaching members and ensuring connection to prenatal care. Thirty eight of the 98 non-compliant HEDIS PPC-Timeliness of Prenatal Care members referred to GFHC successfully completed a timely prenatal care visit achieving a 38.78% success rate. Three members reported SDoH needs during screenings and all three needs were met by GFHC staff. • Meridian referred 165 HEDIS PPC-Timeliness of Prenatal Care measure non-compliant members to the Meridian CHW team in 2022. Twenty-five members were successfully contacted by a member of the CHW team, 15% success rate. Of the 25 members contacted by CHWs, six members became numerator compliant in MY 2022 for the Timeliness of Prenatal Care measure.
c. Identify any barriers to implementing initiatives: • Timely identification of pregnant members is a primary barrier impacting the implementation of HEDIS PPC Timeliness of Prenatal Care interventions. Provider and member notification of pregnancy to the health plan is low. Additionally, claims logic is used to proactively identify members to help more effectively identify members. • Members are often difficult to reach due to inaccessible or inoperable contact information. As a result, members are often unaware of the myriad of available resources and incentives to assist members to attain timely prenatal care visits and other needed resources.
HSAG Assessment: HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendation. The MHP revisited its causal/barrier analysis to identify barriers to care and developed targeted intervention strategies.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **Meridian Health Plan of Michigan**'s performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. • **Meridian Health Plan of Michigan**'s performance for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure indicator ranked below the 25th percentile, and the *HbA1c Control (<8.0%)* measure indicator ranked between the 25th percentile and 49th percentile, indicating that members with diabetes did not aways have controlled HbA1c levels. HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled HbA1c levels. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators. • **Meridian Health Plan of Michigan**'s performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Ages 75 to 85 Years* measure indicators ranked below the 25th

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
percentile, and the *Total* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure. • **Meridian Health Plan of Michigan**'s performance for the *Controlling High Blood Pressure* measure ranked below the 25th percentile, indicating that some members with a diagnosis of hypertension did not have controlled blood pressure. HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with hypertension did not have controlled blood pressure. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Controlling High Blood Pressure* measure. • **Meridian Health Plan of Michigan**'s performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for cervical cancer. HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure. • **Meridian Health Plan of Michigan**'s performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure. • **Meridian Health Plan of Michigan**'s performance for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have an eye exam to screen or monitor for diabetic retinal disease. HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have an eye exam performed. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator. • **Meridian Health Plan of Michigan**'s performance for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not have controlled blood pressure. HSAG recommends that **Meridian Health Plan of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes did not have controlled blood pressure. Upon identification of a root cause, **Meridian Health Plan of Michigan** should implement appropriate interventions to improve the performance related to the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

In response to the External Technical Quality Report (EQR), Meridian evaluated as well as implemented a mixture of progressive and traditional initiatives to enhance the performance of prioritized measures, which includes telephonic and mail outreach, gift card incentives, and diversified methods of educating and incentivizing network providers. Meridian implemented innovative, evidenced-based, member-focused initiatives to appeal to its diverse population. To address identified access and educational barriers, Meridian expanded vendor partnerships for texting outreach campaigns, and supported preventive health community events. Initiatives will continue to be monitored and adjusted to ensure performance improvement.

- Meridian comprehensive analysis of *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30)* identified opportunities to enhance measure outcomes. In 2022, Meridian partnered with mPulse for interactive text messaging services to provide W30 health education, care gap reminders, collect barrier assessment data, and offer appointment scheduling assistance to members due for well child visits. Member gift card incentives are offered for successful completion of W30 measure visits. Meridian added W30 measure data to the provider HEDIS QRG. This data addition is intended to help providers increase W30 completion rates. The QRG contains product lines, measure description, billing codes to meet measure compliance requirements. The QRG is updated annually with the release of the NCQA tech specs and is available year-round on our provider website for easy electronic access.
- Meridian's comprehensive analysis of the chronic condition measures, Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Control (<8.0%) and HbA1c Poor Control (>9.0%) identified a necessity to implement progressive initiatives in addition to existing traditional yet proven interventions such as telephonic outreach and member mailers. Meridian expanded vendor partnerships to complete in-home HbA1c tests or provide in-home HbA1c testing kits to members due for services. Meridian also held quarterly Consumer Advisory Committee (CAC) meetings to gain a thorough understanding of member barriers associated with attaining preventive and chronic care services.
- Meridian's analysis of the HEDIS measure, Kidney Health Evaluation for patients with Diabetes (KED) identified opportunities to develop diverse member outreach methods such as HEDIS Passport mailers which incentivizes and provides friendly health reminders of outstanding HEDIS services for members. The analysis also revealed opportunities to expand vendor relationships in 2022 to include in-home KED screening kits. Meridian also continued the Meridian Risk for Kidney Failure Program which supports the KED measure. In 2022, Meridian proactively sent text message reminders to eligible members due for the KED HEDIS measure. Meridian added the KED measure information to the new Provider (QRG) which delivers measure screening requirements and coding, efficiently.
- Meridian's analysis of the 2022 HEDIS measure, Controlling High Blood Pressure (CBP), revealed a need to provide additional measure education and supportive resources to members and providers. In response, CBP measure information was added to the Provider (QRG) which is an efficient provider resource that allows providers to easily access pertinent CBP measure information to decrease the prevalence of missed opportunities and enhance measure performance. In 2022, Meridian implemented member texting campaigns aimed to increase CBP compliance. Meridian also sent HEDIS passport

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
mailers to non-compliant CBP measure members to encourage measure compliance. Meridian implemented the CBP Provider Education initiative for Medicaid providers, which targets provider who filed claims for CBP but failed to document blood pressure results in the medical chart. Meridian implemented the Blood Pressure (BP) cuffs outreach initiative, which provided blood pressure monitoring cuffs to members and mailed CBP post cards to remind members to schedule blood pressure check visits with their providers. • Meridian is leveraging every opportunity to improve the outcomes of the HEDIS *Cervical Cancer Screening (CCS)* measure by supporting and participating in community events that provide preventive health care screenings. Scheduled for October 2023, the first Federally Qualified Health Center (FQHC) Women's Health Event will be held. A women's pampering event targeting awareness of *Cervical Cancer Screenings and Breast Cancer Screenings*. During this event, prizes and free pampering services will be offered to members while medical staff complete preventive screenings. Meridian has also expanded member outreach and texting campaigns to bring awareness to the importance of *Cervical Cancer Screening* by launching a targeted campaign for cervical cancer awareness month in addition to CCS health reminders. CCS measure data is also included in the Provider QRG to efficiently reference best practices to improve CCS rate performance. • Meridian implemented several initiatives for the *Breast Cancer Screening (BCS)* measure to improve measure performance including supporting community events to provide preventive health screenings, expand partnerships, and developed targeted provider education and resources. Member gift card incentives are offered for successful completion of Breast Cancer Screenings in 2022 and 2023. BCS measure data was added to the Provider QRG for efficient measure education referencing. Meridian implemented a BCS text messaging campaign with vendor partner, mPulse. These campaigns target members who are due or overdue for Breast Cancer Screenings. Meridian also partnered with Ascension Health Mobile mammography unit to perform mammograms for members in communities where they work and live. Ascension Mammovans partnership allows for year-round appointment scheduling. • In 2022, Meridian's analysis of the HEDIS Comprehensive Diabetes Care—Eye Exam (EED) measure substantiated the continuation of traditional outreach interventions such as telephonic outreach campaigns. In addition, Meridian also executed digital communication campaigns to provide measure education and reminders to members via email and text messaging. Meridian incentivized members with $25 gift cards upon completion of a diabetic eye exam. To address access barriers, Meridian provides in-home diabetic retinal eye exam (DRE) services to members at no cost, through an external vendor partnership. Meridian sends HEDIS passport mailers to non-compliant members and incentivizes for measure compliance. The EED measure was added to the QRG, also. • Analysis of the Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg (CDC-BPD) confirmed ongoing initiatives such as telephonic, mailers, email, and text messaging campaigns adequately aim to improve measure performance through the provision of education and screening reminders. To better support providers, Meridian added CDC-BPD measure data to the QRG as a priority measure. The QRG delivers pertinent blood pressure screening information, which includes billing codes to increase compliance and decrease missed opportunities. Additionally, Meridian sent HEDIS passport incentive mailers to gently remind members to complete diabetic screenings and members also received Blood Pressure (BP) Cuffs. • Meridian will continue the prioritization of educational outreach, resource, and care coordination, as well as ensure optimal access to care for its membership population. To achieve improvement goals, Meridian leveraged in-house Care Coordination staff to provide HEDIS information and reminders. Also, participated in quarterly Consumer Advisory Committee (CAC) meetings to better understand

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
member barriers associated with attaining preventative and chronic care services. Meridian also focuses on reducing health disparities and SDoH to enhance measure performance outcomes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • In 2023, Meridian detected a 2.41% increase in *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* over 2022 final rates. Increasing from a 59.29% final rate in 2022 to a current rate of 61.70% as of August 2023. • Meridian observed an increase of 14.40% for the *Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Control (<8.0%)* when comparing the final CY21 HEDIS rates to final CY22 HEDIS rates. Upon further investigation, the final HEDIS rate for CY21 increased from 40.60% to 55% in CY2022. Based on a one year to date analysis of HBD, Meridian's current HBD rate in August 2023 is 15% higher than the August 2022 measure rate and are projected to exceed the final rates of CY22. • The *Controlling Blood Pressure (CBP*) measure rate increased 13.10% when comparing the final HEDIS rates from CY21 at 48.90% to CY22 at 62%. Based on the one-year lookback analysis for CBP, Meridian's current rate for August 2023 is trending 8.70% higher than August 2022 CBP rates. • Meridian identified a 3.50% increase in *Cervical Cancer Screenings* when comparing final rates from CY2021 to CY2022. Increasing from a 56.80% final rate in 2021 to a final rate of 60.30% in 2022. In a one year to date lookback analysis the current rate in August 2023 shows CCS rates are 2.90% higher than in August 2022 and are trending to show continued improvement. • Meridian observed a 2.60% increase in *Breast Cancer Screening* final rates from 2021 to 2022. Increasing from a 50.90% final rate in 2021 to a final rate of 53.50% in 2022. In a one year to date lookback analysis, the current rate in August 2023 shows BCS rates are 1% higher than in August 2022 and are projected to exceed final rates of 2022. • Meridian identified a 3.90% increase in *Comprehensive Diabetes Care—Eye Exam (EED)* when comparing the final HEDIS CY21 rate of 51.30%% to final CY22 rate of 55.20%. Based on the year over year comparison for EED, Meridian observed the current rate for August 2023 is 3.20 % higher than August 2022 DRE rates. • Meridian observed a 12.20% increase in the HEDIS Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg (CDC-BPD) when comparing the final HEDIS rate from CY21 at 55.70% to CY22 at 67.90%. Based on a year over year comparison for BPD, Meridian observed the current rate for August 2023 is 8.50 % higher than August 2022 CBP rates.
c. Identify any barriers to implementing initiatives: Meridian strives to identify and address any potential barriers identified before, during, and after the implementation of interventions. For each initiative implemented addressing HSAG recommendations, the following barriers have been identified. • The effectiveness of member outreach is often hindered by members' failure to provide updated phone and address information to Meridian. Data collected during texting campaigns have highlighted the criticality of maintaining accurate contact information. Providers fail to reference the QRG as a resource, resulting in missed compliance opportunities. • Members may elect to opt out of in home testing and exam opportunities. Members often miss scheduled appointments for in home test kits and exams adversely impacting measure performance. Members request to be added to the vendor's Do Not Call list. • Large volume of non-compliant CBP and BPD population inhibit effectiveness and success of the CBP BP cuff initiative; resource constraints and limitations with providing a BP cuff to every member.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
Additionally, success for these two measures is heavily reliant upon medical record reviews which presents additional layers of complexity with proactive compliance monitoring. • The mobile mammography units have limited scheduling per day and overall limited availability throughout the year. Data reveals previously held events had high cancellation and no-show rates. Transportation barriers to mammogram appointments has also had an impact upon the success BCS measure outcomes.
HSAG Assessment: HSAG has determined that **Meridian Health Plan of Michigan** has partially addressed the prior year's recommendations. **Meridian Health Plan of Michigan** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator by the use of interactive text messaging services to provide health education on well-child visits, sending care gap reminders, collecting barrier assessment data, offering appointment scheduling assistance to members, and giving member gift card incentives for successful completion of well-child visits. However, **Meridian Health Plan of Michigan** continues to demonstrate low performance for the measure indicator, with the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator ranking below the 25th percentile for MY 2022. HSAG recommends continued efforts by **Meridian Health Plan of Michigan** to improve performance for the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator and monitoring of initiatives currently in place to ensure continued improved performance. HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendation for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators. **Meridian Health Plan of Michigan** conducted a root cause analysis to determine why some members with diabetes did not have controlled HbA1c levels and implemented initiatives such as conducting telephonic and mailed outreach to members, expanding vendor partnerships to complete in-home HbA1c tests or in-home HbA1c testing kits to members, and holding quarterly CAC meetings to gain a thorough understanding of member barriers associated with attaining preventive and chronic care services. Additionally, the rates significantly increased from the prior measurement year and ranked in the 50th to 74th percentile and the 75th to 89th percentile, respectively, for MY 2022, demonstrating improved performance. Regarding HSAG's prior year recommendation for the *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Ages 75 to 85 Years* measure indicators, **Meridian Health Plan of Michigan** has demonstrated efforts by identifying opportunities to develop diverse member outreach methods, expanding vendor relationships to include in-home KED screening kits, continuing the Meridian Risk for Kidney Failure Program in support of the measure, and sending text message reminders to members due for services. While the measure indicator rate for *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* increased from the prior year and is now ranking between the 50th and 74th percentile, **Meridian Health Plan of Michigan** continues to demonstrate low performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* measure indicator by ranking between the 25th and 49th percentile for MY 2022. HSAG therefore recommends that **Meridian Health Plan of Michigan** continue its efforts on further improving the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* rate and monitoring the impact of initiatives currently in place to ensure improved performance. HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendation for the *Controlling High Blood Pressure* measure. **Meridian Health Plan of Michigan** conducted a root cause analysis to determine why some members with a diagnosis of hypertension did not have controlled blood

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
pressure and implemented initiatives such as providing measure education and resources to members and providers, implementing member texting campaigns, sending mailers to members, and implementing an outreach initiative. Additionally, the rate significantly increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendation for the *Cervical Cancer Screening* measure. **Meridian Health Plan of Michigan** conducted a root cause analysis to determine why some women were not always being screened for cervical cancer and implemented initiatives such as participating in community events that provided preventive healthcare screenings, hosting events targeting awareness and completion of cervical cancer screenings, expanding its member outreach and texting campaigns, and providing education to providers. Additionally, the rate increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendation for the *Breast Cancer Screening* measure. **Meridian Health Plan of Michigan** conducted a root cause analysis to determine why some women were not always being screened for breast cancer and implemented initiatives such as participating in community events that provided preventive healthcare screenings, hosting events targeting awareness and completion of breast cancer screenings, providing targeted provider education and resources, giving member incentives, conducting a text messaging campaign with its vendor partner, and partnering with the Ascension Health Mobile mammography unit to perform mammograms for members in communities where they work and live. Additionally, the rate significantly increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendation for the *Eye Exam for Patients With Diabetes* measure. **Meridian Health Plan of Michigan** conducted a root cause analysis to determine why some members with diabetes did not have an eye exam to screen or monitor for diabetic retinal disease and implemented initiatives such as conducting telephonic outreach campaigns, executing digital communication campaigns to provide measure education and reminders to members, giving member incentives upon completion of eye exams, providing in-home diabetic retinal eye exam services to members at no cost, and sending mailers to noncompliant members. Additionally, the rate increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendation for the *Blood Pressure Control for Patients With Diabetes* measure. **Meridian Health Plan of Michigan** conducted a root cause analysis to determine why some members with diabetes did not have controlled blood pressure and implemented initiatives such as conducting outreach campaigns, providing member and provider education, and sending screening reminders. Additionally, the rate significantly increased from the prior measurement year and ranked in the 75th to 89th percentile for MY 2022, demonstrating improved performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Meridian Health Plan of Michigan** scored below the statewide average in the Member standard. The MHP received a *Not Met* score for elements *3.3 Member Newsletters* and *3.26 Diversity, Equity, and Inclusion (DEI) Assessment and Training*. As **Meridian Health Plan of Michigan** previously submitted a CAP to address element 3.3, which was approved by MDHHS, HSAG recommends **Meridian Health Plan of Michigan** ensure its CAP is fully implemented to mitigate the deficiencies. MDHHS did not require the MHP to submit a CAP to address element 3.26; therefore, HSAG recommends that **Meridian Health Plan of Michigan** develop an action plan to fully address MDHHS' DEI assessment and training requirements and ensure timely submission during future compliance reviews. • **Meridian Health Plan of Michigan** scored below the statewide average in the MIS standard. The MHP received a *Not Met* score for elements *5.11 Claims Processing (Non-Pharmacy)* and *5.15 Monthly Encounter Record Acceptance Rate in CHAMPS* (the MHP was cited twice for element 5.15). As **Meridian Health Plan of Michigan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **Meridian Health Plan of Michigan** ensure its CAP is fully implemented to mitigate the deficiencies. However, while **Meridian Health Plan of Michigan**'s CAP was approved, MDHHS requested several CAP revisions and previously expressed concerns that the MHP had not made sufficient improvements. To further enhance the MHP's efforts to improve the accuracy and consistency of encounter data reported to MDHHS, HSAG recommends that **Meridian Health Plan of Michigan** use the results of future encounter data validation activities to determine whether additional processes should be implemented to enhance the accuracy of data reported to MDHHS.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **3.3 Member Newsletter** - Meridian was missing the one-page nondiscrimination notice (NDN) notice within the Member newsletter. This was addressed by adding additional information to Meridian's newsletter. This has been completed and will be maintained in future newsletters. • **3.26 DEI Assessment and Training** - Meridian completed the 3.26 Compliance Review Criteria for the July submission, however due to an administrative error, the submission was left out of the packet submitted to MDHHS. To ensure this error does not occur again, Meridian has added extra validation steps within the review process before Compliance Review submissions are uploaded for MDHHS review. • **5.11 Claims Processing** - After evaluating of the four impacted MSA [Medical Services Administration] claims reports for September 2021, March 2022, April 2022 and May 2022, Meridian determined the reports were inaccurate due to an improper amount inserted on Line 2. Meridian tracks all data in an external document, when transferring the information from Meridian's tracker to the MSA 2009 report the information from Line 2 was mistakenly entered with inaccurate data. Therefore, the total amounts on Line 11 were reflecting the correct numbers, while Line 2 was showing incorrect amounts. Meridian has updated the impacted reports, and Line 2 has now been updated on each report to display the initial, accurate amount to align with the total calculation on Line 11 on each report. This has been updated and Meridian has added additional checks and balances to ensure the reports accuracy prior to submission.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
• **5.15 Monthly Encounter Record Acceptance Rate in CHAMPS** - Meridian was not meeting the 95% benchmark for Professional and Institutional encounters. To address this and move towards the benchmark Meridian established a weekly Encounter Engagement meeting with all operational departments that are required to make encounter submissions successful. Meridian tracked the volume of errors occurring in encounter acceptance and used this to conduct a root cause analysis. Once the root cause was identified, teams worked within the weekly workgroup to ensure fixes and solutions were put into place.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Additional checks and balances put in place for 3.3, 3.26 and 5.11 were implemented as best practices to ensure all data and submission go through and extra level of review before submission to MDHHS.
- To ensure benchmarks were met for 5.15 Meridian updated logic that resulted in an increase in Institutional and Professional encounters being accepted with the MDHHS system. Meridian has been meeting benchmarks for the past nine months.

	Institutional		Professional	
TCN Create Date	**% Encounters Accepted**	**Threshold Met**	**% Encounters Accepted**	**Threshold Met**
Oct-22	95%	**YES**	92%	**NO**
Nov-22	97%	**YES**	91%	**NO**
Dec-22	97%	**YES**	96%	**YES**
Jan-23	95%	**YES**	95%	**YES**
Feb-23	95%	**YES**	95%	**YES**
Mar-23	97%	**YES**	97%	**YES**
Apr-23	96%	**YES**	95%	**YES**
May-23	96%	**YES**	95%	**YES**
Jun-23	96%	**YES**	97%	**YES**
Jul-23	95%	**YES**	95%	**YES**

c. Identify any barriers to implementing initiatives:

- 3.3, 3.26 and 5.11 had no barriers to implementing initiative to achieve compliance.
- Meridian has been working diligently to maintain and increase acceptance rates for 5.15. MDHHS does plan to increase the benchmark from 95% to 97% for FY24. Meridian could run into barriers meeting the increased benchmark. Some of these encounter errors come from within the MDHHS Encounters system. The system issues that create rejections at the MDHHS level (and outside of the plans' control) negatively impacts plans acceptance rate calculation.

HSAG Assessment: HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendations. The SFY 2023 compliance review activity confirmed that **Meridian Health Plan of Michigan** received a *Met* score for elements 3.3 and 3.26. However, while **Meridian Health Plan of Michigan** implemented initiatives to address the deficiencies for elements 5.11 and 5.15, these initiatives do not appear to have been fully successful as the MHP continued to receive received a *Not Met* score for elements 5.11 and 5.15 during the SFY 2023 compliance review. **Meridian Health Plan of Michigan** submitted a CAP to MDHHS, and the CAP was approved and closed as of November 2023. HSAG recommends that **Meridian Health Plan of Michigan** continue to monitor compliance with requirements for claims processing and also

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
ensure that **Meridian Health Plan of Michigan** meets the 95 percent threshold for the monthly encounter record acceptance rate.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • Overall, 8.8 percent of the sampled providers listed in **Meridian Health Plan of Michigan**'s provider data could not be located in **Meridian Health Plan of Michigan**'s online provider directory. Among the provider categories, 11.6 percent of pediatric providers, 10.7 percent of PCP providers, and 4.1 percent of OB/GYN providers could not be located in the online directory. **Meridian Health Plan of Michigan**'s provider data included invalid provider information. HSAG recommends that **Meridian Health Plan of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies. • Only 75.5 percent of the sampled provider locations could be reached. In addition to the limitations related to the secret shopper approach, **Meridian Health Plan of Michigan**'s provider data included invalid telephone information. While HSAG only contacted phone numbers matching the online provider directory, the PDV review indicated only 68.3 percent of **Meridian Health Plan of Michigan**'s phone numbers in the provider data aligned with the online directory. HSAG recommends that **Meridian Health Plan of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies. • Of cases in which the survey respondent reported that the provider location accepted **Meridian Health Plan of Michigan**, MI Medicaid, and new patients, 70.5 percent of cases offered an appointment date. PCP provider locations had an appointment availability rate of 76.0 percent. Both pediatric and OB/GYN provider locations had an appointment availability rate of 66.7 percent. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. HSAG recommends that **Meridian Health Plan of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Meridian Health Plan of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Provider Directory and Demographic**: Meridian worked diligently throughout FY23 to ensure the accuracy of our Provider directory. Meridian completed multiple initiatives such as monthly auditing, review of file feeds, implementation of demographic forms on the Meridian website and restructuring of provider facing teams. Meridian's Compliance team is worked with the Network team, IT, and Provider Relations and the Contract team to further enhance the level of scrutiny, accountability, and oversight. Monthly audits of the Provider Directory against the 4275 are also conducted to ensure information is matching. These enhancements would greatly contribute towards the internal efforts to improve data accuracy within our Provider Directory. With there being thousands of providers,

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
Meridian also is making sure that Meridian Provider Representatives are reviewing the provider contact information on a regular basis in person and in virtual meetings. The providers will also send the representatives any updated information and the representatives in return will submit the changes into our system accordingly. The Network team is encouraging all providers to utilize the web form to submit demographic and enrollment updates through the newsletter that is provided to them. Representatives will continue to direct providers to the web form process on our website for submitting new providers and updating their information. Meridian also worked to restructure its Network teams to ensure timely responses with contracting, demographics, and questions. • **Appointment and Provider Availability** – Meridian conducts annual Appointment Access audits along with regular Network Access Report. The Appointment Access audits are done on a sample of the Medicaid provider population to ensure that providers are following appointment guidelines outlined within the contract. o Meridian has a large state-wide network that includes over 45,000 practitioners and 6,000 PCPs. Meridian has established many key partnerships to meet the needs of our large membership, including FQHCs, rural health clinics (RHCs), hospitals, OB/GYNs, MIHPs and all needed specialty and ancillary services. The contracted PCP network is committed to member engagement as evidenced by our large percentage of open accepting PCPs at over 75% average across all locations. In the rare event one of our providers are not able to meet the needs of an enrollee, out-of-network care is available, and claims are paid out-of-network at 100% of the Medicaid fee schedule. This extends the reach of Meridian's provider network and ensures members always have access to care. o During the 2022 calendar year, Meridian's Credentialing Specialists credentialed 4,352 providers, and at the end of the year Meridian had 34,103 providers enrolled with Meridian's Medicaid plan. o Meridian also covers telehealth services to create better access and availability for our enrollees. Telehealth removes physical and travel barriers as a deterrent to obtaining needed services. This approach allows physicians to communicate and, in some cases, resolve enrollees' concerns without a face-to-face visit.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Provider Directory Auditing and Update Initiative** - A Meridian Compliance Specialist audits the provided 4275 information against the web-based Provider Directory and calls out to providers to verify locations and the acceptance of new patients. Results are then captured in oversight dashboards and shared with Provider Relations & Contracting Business Owners. Compliance requests that these Business Owners correct any discrepancies and confirm results within three business days. For any confirmed discrepancies, a Meridian will perform a secondary audit in the next month to ensure discrepancies have been updated on the web-based Provider Directory. If the results remain incorrect, Meridian will issue an internal Corrective Action Plan to track remediation of findings in a timely manner. While implementing our new process, as of September 2022 to April 2023, there has been an improvement on the second portion of the audit. The findings that are being corrected by the Network team has increased an average of 15%, showing progress of the Provider Directory. Along with that, in comparison to our 4275 file and the directory, there has been improvement on the accuracy of similarity resulting in April scoring a 100%. The weekly updates of the 4275 files have helped our audit and will continue to do so in the long run. • **Provider Demographic Form Initiative**: From September 2022 to April 2023, there was a total of 1,372 provider demographic submissions. During these months, a total of 642 submissions have been completed within their 5-day Service Level Agreement (SLA) turnaround timeframe. Meridian also

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
completed 739 submissions by making outreaches to the Provider resulting in an average of a 12-day turnaround. For the contracted enrollment section of the directory, from September 2022 to April 2023, there were a total of 2,701 enrollments. Altogether, 581 enrollments were completed within their 5-day SLA making and an additional 2,113 completed outside of a 5 day turn around. This process has helped with updating Provider information timelier and is starting to show improvements in our Provider data. • **Appointment and Provider Availability** – Since COVID-19 Meridian has seen many providers with limited hours and appointment availability. Meridian continues to monitor appointment access and also cover telemedicine to increase access.
c. Identify any barriers to implementing initiatives: • If providers do not report changes it makes it difficult for plan to have accurate information. Suggest one form or platform provider can update information for all Medicaid health plans. • The Network team worked through a barrier of the large inventory being submitted throughout the months due to limited staffing. • Meridian has run into barriers with provider access in some rural counties. This can be contributed to the lack of specialty types in some of these areas. Meridian continues to bring on any willing an available provider in this area. To help mitigate this Meridian does operate with an open network.
HSAG Assessment: HSAG has determined that **Meridian Health Plan of Michigan** addressed the prior year's recommendation, as noted through its monitoring and validation efforts and other initiatives. However, the MHP should continue these efforts to ensure members have accurate information available to make appointments and to ensure any barriers to accessing care are mitigated.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG recommended the following: **Adult and Child Medicaid** • **Meridian Health Plan of Michigan**'s 2022 top-box scores were statistically significantly lower than the 2021 NCQA adult Medicaid national averages for two measures: *Rating of All Health Care* and *Coordination of Care*. When compared to national benchmarks, the results indicate that **Meridian Health Plan of Michigan** members are reporting more negative experiences with their child's healthcare and coordination of care. HSAG recommends that **Meridian Health Plan of Michigan** focus on improving members' overall experiences with their healthcare and identifying the root cause of the poorer experiences with their coordination of care. **CSHCS** • **Meridian Health Plan of Michigan**'s 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Customer Service*. When compared to national benchmarks, the results indicate that parents/caretakers of child members enrolled in **Meridian Health Plan of Michigan** may not be receiving the information or help needed or may be dissatisfied with the level of courtesy and respect offered by customer service staff members. HSAG recommends that **Meridian Health Plan of Michigan** explore drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **Meridian Health Plan of Michigan** should consider obtaining direct patient feedback from members to drill down into areas that need improvement. **HMP** • **Meridian Health Plan of Michigan**'s 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, *Getting Needed Care*. When compared to national benchmarks, the results indicate that **Meridian Health Plan of Michigan**'s members are reporting

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
more negative experiences with getting the care, tests, treatment, or specialist appointment they need. HSAG recommends that **Meridian Health Plan of Michigan** explore the drivers of this lower experience score and develop initiatives designed to improve members' quality of care. In addition, **Meridian Health Plan of Michigan** should identify any barriers to accessing healthcare (e.g., transportation, geography) and work toward removing these barriers, so members have better access to care.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: The following interventions were implemented to enhance Meridian's CAHPS rankings: • Member and Provider Satisfaction Workgroup: Representatives from various departments (Quality, Customer Experience, Medical Management, Utilization Management, Vendor Management, Network Management, Pharmacy) participate in monthly workgroup meetings aimed to strategically identify solutions and implement initiatives to enhance members and providers satisfaction. • CAHPS Training: In February 2022, the Quality department facilitated live CAHPS training for all member and provider-facing staff. The initiative will continue, annually. • Consumer Advisory Council (CAC) Meetings: Quarterly meetings are held with members including members from Children's Special Health Care Services (CSHCS) population, various State and health plan representatives to increase Meridian's understanding of member preferences, experiences, barriers, and to encourage suggested recommendations for improvement. CAC meetings specifically addressed access to care issues such as transportation barriers and alleviation methods. • CAHPS Best Practices: Leveraged Centene Corporate resources to acquire and incorporate CAHPS best practices to improve Meridian's CAHPS outcomes. • Providing-Facing Staff Presentations: In January 2023, Meridian held monthly meetings with high-volume provider groups to discuss various quality initiatives with a prioritized focus upon Coordination of Care measure. • Provider CAHPS Summit: In November 2022, Collaborated with Centene's Corporate Quality Improvement to host a provider summit for Meridian's network providers focused on improving the patient experience and CAHPS scores. • Member Impact Team: Expanded the Quality department's member-facing team to increase member outreach and to maximize positive outcomes of prioritized quality initiatives. • CAHPS Detractor Campaign: In March 2023, the Quality Improvement Member Impact team launched member outreach campaigns targeting members with poorly rated health plan experiences according to mock CAHPS surveys. During the outreach calls, staff provided plan benefit reminders and helped address any unresolved issues that may have affected members' health plan satisfaction. • CAHPS Survey Pre-Conditioning: In January 2023, postcards were sent to members reinforcing positive health plan aspects, reminding members to contact the health plan with any questions or issues, and encouraged members to complete the CAHPS survey, if received. • CAHPS Training for Staff: In June 2023, launched a new member-facing staff training module designed to remind teams of their crucial role and impact upon CAHPS outcomes. The training also reiterates the importance of always providing excellent service to our members.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
• Access and Availability Audits: Bi-annual audits are conducted by an external vendor (Faneuil) to ensure the provider network remains efficient and meets member needs. Also, ensures providers are following recommended appointment scheduling guidelines.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Medicaid CAHPS measures Getting Needed Care, Getting Care Quickly, Coordination of Care, Rating of Health Care, Rating of Specialist, Rating Personal Dr, Rating of Health Plan, Smoking Cessation, and Flu Vaccinations experienced a year over year improvement, 2022 to 2023. • Meridian Specialists met the geo-access and availability standards per the Network Adequacy and Accessibility audit.
c. Identify any barriers to implementing initiatives: • Budget limitations impact the ability to implement planned initiatives. • Limited responses on CAHPS surveys present difficulty with gaining granular insight of members' health care and health plan experiences, necessary to make informed improvements.
HSAG Assessment: HSAG has determined that **Meridian Health Plan of Michigan** has addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **Meridian Health Plan of Michigan**'s scores for *Rating of Health Care* and *Coordination of Care* were comparable to the 2022 NCQA adult Medicaid national average for the adult Medicaid population. **Meridian Health Plan of Michigan**'s 2023 score for *Coordination of Care* was also statistically significantly higher than the 2022 score for the adult Medicaid population. **Meridian Health Plan of Michigan**'s score for *Customer Service* for the CSHCS population was comparable to the 2022 NCQA child Medicaid national average. Furthermore, **Meridian Health Plan of Michigan**'s score for *Getting Needed Care* was also comparable to the 2022 NCQA adult Medicaid national average for the HMP population. However, **Meridian Health Plan of Michigan** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **Meridian Health Plan of Michigan** continue to implement performance improvement interventions and evaluate their effectiveness.

Molina Healthcare of Michigan

Table 4-6—Prior Year Recommendations and Responses for MOL

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although no weaknesses were identified, HSAG recommends **Molina Healthcare of Michigan** use appropriate causal/barrier analysis methods to identify barriers to care and implement interventions to address those barriers in a timely manner.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Addressing Disparities in Timeliness of Prenatal Care: • To increase the number of Black members identified at the earliest point in their pregnancies, Molina Healthcare implemented a daily pregnancy-specific algorithm to all submitted claims. The reports are available on demand and allows for timely outreach, ensuring members are connected to pregnancy care and resources earlier in the pregnancy. • Black members are referred to Mae Health and the WIN Network as early as identified as pregnant (in specific geographic areas), and members without a HEDIS-compliant prenatal visit are referred to Ouma Health for a telephonic prenatal visit, which includes a car seat incentive for completion. • Molina members are contacted by email, member's most preferred method of outreach, to deliver information related to prenatal care and resources. • Molina members are offered a gift card incentive for the completion of a prenatal visit within the first trimester of their pregnancy, or within 42 days of health plan enrollment.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Implementing the new daily pregnancy specific algorithm resulted in a 121% increase in early identification of pregnant members. • Molina members opened thirty-nine (39) percent of emails sent regarding the prenatal program. • A review of the RY 2023 HEDIS performance rates by race/ethnicity revealed the rate for Black members, reported at 68.51%, which is 2.31 percentage points above the HEDIS RY2022 rate of 66.20%
c. Identify any barriers to implementing initiatives: • There are no barriers identified to implementing the initiatives listed above.
HSAG Assessment: HSAG has determined that **Molina Healthcare of Michigan** addressed the prior year's recommendation. The MHP revisited its causal/barrier analysis to identify barriers to care and developed targeted intervention strategies.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **Molina Healthcare of Michigan**'s performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. • **Molina Healthcare of Michigan**'s performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for cervical cancer. HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure. • **Molina Healthcare of Michigan**'s performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure. • **Molina Healthcare of Michigan**'s performance for all *Kidney Health Evaluation for Patients With Diabetes* measure indicators ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. HSAG recommends that **Molina Healthcare of Michigan** conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Molina Healthcare of Michigan** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—*Two or More Well-Child Visits: To encourage the completion of Well-Child visits, parents/guardians are contacted by email, phone, mail and by sending member newsletters to provide information regarding the importance of the Well-Child visits and what to expect during the visits. Mailings include the distribution of the Pathway 2 a Healthy Childhood magnet within a month after the member's birth, to serve as a reference for members' parents and guardians regarding the cadence and schedule of all well child visits. The information is offered in Arabic, English and Spanish in accordance with the parent/guardian's primary language. Medical providers are forwarded lists of their patients who are due

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
or overdue for these visits and provided information to improve the performance rate with HEDIS Tip Sheets by email and during on-site and virtual visits. • *Cervical Cancer Screening*: Members are contacted by text, email, phone, and by mail to remind them to schedule and complete a cervical cancer screen. Outreach materials are provided in Arabic, English and Spanish. Outreach materials address privacy and cultural preferences. Members are offered a gift card incentive to complete the Cervical Cancer Screen within the calendar year. Medical providers are forwarded lists of their patients who are due or overdue for these visits and provided information to improve the performance rate with HEDIS Tip Sheets by email and during on-site and virtual visits. • *Breast Cancer Screening*: Members are contacted by email, phone, and by mail to remind them to schedule and complete a breast cancer screen. Outreach materials are provided in Arabic, English and Spanish. Members are also notified of opportunities for complete the mammogram at mobile mammogram events. Members are offered a gift card incentive to complete the Breast Cancer Screen within the calendar year. Primary Care Providers are offered an incentive for each patient who receives a mammogram during the measurement year. Medical providers are forwarded lists of their patients who are due or overdue for these visits and provided information to improve the performance rate using HEDIS Tip Sheets by email and during on-site and virtual visits. • *Kidney Health Evaluation for Patients With Diabetes*: Primary Care Providers receive information by email, within HEDIS Measure Tip Sheets and during on-sites and virtual visits to explain the tests needed for compliance with this measure. Provides receive an incentive for each patient who receives a serum eGFR and urine ACR. Medical providers are forwarded lists of their patients who are due or overdue for these visits and provided information to improve the performance rate using HEDIS Tip Sheets by email and during on-site and virtual visits.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30)*: The HEDIS MY 2021 rate of 60.53% improved by 1.77 percentage points to 62.30% (HEDIS MY 2022). • *Cervical Cancer Screening (CCS)*: The HEDIS MY 2021 rate of 57.21% increased by 2.16 percentage points to 59.37% (HEDIS MY 2022). • *Breast Cancer Screening (BCS)*: The HEDIS MY 2021 rate of 51.37% increased by 2.11 percentage points to 53.487% (HEDIS MY 2022). • *Kidney Health Evaluation for Patients With Diabetes (KED)*: The HEDIS MY 2021 rate of 27.91% improved by 1.16 percentage points to 29.07% (HEDIS MY 2022).
c. Identify any barriers to implementing initiatives: • Member outreach is negatively impacted when phone numbers are not correct, or the member does not answer the phone. • The reach rate for emails is higher than by phone, but it lacks the ability to have a conversation with the member. • There is slow adoption to ordering the serum eGFR and urine ACR tests, for the KED measure. Continued education and additional discussion with the site leadership is needed to make changes in their current processes.
HSAG Assessment: HSAG has determined that **Molina Healthcare of Michigan** has partially addressed the prior year's recommendations. **Molina Healthcare of Michigan** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator by encouraging completion of well-

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
child visits by contacting parents/guardians through various outreach methods and providing information regarding the importance of well-child visits, and forwarding lists of patients due or overdue for well-child visits to providers. While the measure indicator rate significantly improved from the prior year, **Molina Healthcare of Michigan** continues to demonstrate low performance for the measure indicator, with the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator ranking between the 25th and 49th percentile for MY 2022. HSAG recommends continued efforts by **Molina Healthcare of Michigan** to improve performance for the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator and monitoring of initiatives currently in place to ensure continued improved performance. HSAG has determined that **Molina Healthcare of Michigan** addressed the prior year's recommendation for the *Cervical Cancer Screening* measure. **Molina Healthcare of Michigan** conducted a root cause analysis to determine why some women were not always being screened for cervical cancer and implemented initiatives such as conducting various methods of outreach to members to remind them to schedule and complete a cervical cancer screening, giving member incentives, and forwarding lists of patients due or overdue for screenings to providers. Additionally, the rate increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. HSAG has determined that **Molina Healthcare of Michigan** addressed the prior year's recommendation for the *Breast Cancer Screening* measure. **Molina Healthcare of Michigan** conducted a root cause analysis to determine why some women were not always being screened for breast cancer and implemented initiatives such as conducting various methods of outreach to members to remind them to schedule and complete a breast cancer screening, giving member and provider incentives, and forwarding lists of patients due or overdue for screenings to providers. Additionally, the rate significantly increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. Regarding HSAG's prior year recommendation for the *Kidney Health Evaluation for Patients With Diabetes* measure indicators, **Molina Healthcare of Michigan** has demonstrated efforts by providing provider education, giving provider incentives, and forwarding lists of patients due or overdue for kidney evaluations to providers. While the measure indicator rates for *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years* and *Total* significantly increased from the prior year, **Molina Healthcare of Michigan** continues to demonstrate low performance for the *Kidney Health Evaluation for Patients With Diabetes* measure indicators by ranking between the 25th and 49th percentile for MY 2022 for the *Ages 18 to 64 Years*, *Ages 65 to 74 Years*, and *Total* measure indicators, and below the 25th percentile for the *Ages 75 to 85 Years* measure indicator. HSAG therefore recommends that **Molina Healthcare of Michigan** continue its efforts on further improving the *Kidney Health Evaluation for Patients With Diabetes* rates and monitoring the impact of initiatives currently in place to ensure improved performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Molina Healthcare of Michigan** scored below the statewide average in the MIS standard. The MHP received a *Not Met* score for elements *5.8 Third Party Subrogation Requests* and *5.11 Claims Processing (Non-Pharmacy)*. As **Molina Healthcare of Michigan** previously submitted a CAP, or was on an existing CAP, to address these findings which were approved by MDHHS, HSAG recommends **Molina Healthcare of Michigan** ensure its CAP is fully implemented to mitigate the deficiencies.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For 5.8 Third Party Subrogation Requests Molina partnered with its subrogation vendor, Optum, to revise their Standard Operation Procedure (SOP) to ensure compliance with the 30-day response requirements. Optum created a designated referral inbox and high priority queue for MI Medicaid cases. Dedicated staff is allocated to Molina MI with backups available in case of PTO or health leave. Optum automated alerts and escalation for: o If the priority referral queue ages past 5 days, a Case Creation Manager is alerted. o Assess root cause of delay before it ages further (process gap, staffing capacity, etc.) • For 5.11 Claims Processing (Non-Pharmacy) there was no issue with claims processing but just the mechanism that one of Molina's sub-contracted vendors was reporting claims adjustments. Molina's dental vendor was including reprocessed dental claims (due to appeals) in the clean claims report. The dental vendor has been linking these new claims to the original clean date of the claim. This resulted in the opening balance being different than the closing balance that was reported in the prior month. The issue was remediated with the vendor and extra steps were implemented to ensure the numbers balance on the monthly claims submission report.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For 5.8 Third Party Subrogation Requests we have been in compliance with the regulatory requirements. • For 5.11 Claims Processing (Non-Pharmacy) we have been balancing the report for past 12 months and continue to meet compliance metrics.
c. Identify any barriers to implementing initiatives: • For 5.8 Third Party Subrogation Requests there is still a human element to the process so there is risk in missing a case due to the human element of the process. • For 5.11 Claims Processing (Non-Pharmacy) there have been no barriers to implementing the initiative.
HSAG Assessment: HSAG has determined that **Molina Healthcare of Michigan** addressed the prior year's recommendations. The SFY 2023 compliance review activity confirmed that **Molina Healthcare of Michigan** received a *Met* score for elements 5.8 and 5.11.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • Only 68.4 percent of the sampled provider locations could be reached. In addition to the limitations related to the secret shopper approach, **Molina Healthcare of Michigan**'s provider data included invalid telephone or address information when contacting the office staff members. HSAG recommends that **Molina Healthcare of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies. • Only 51.3 percent of the responsive cases reported that the location offered services for the requested specialty. Among these cases, 65.8 percent of the pediatric provider locations offered the specialty services

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
indicated in the online provider directory, 53.1 percent of the PCP provider locations offered the requested specialty services, and 29.1 percent of OB/GYN provider locations offered the requested specialty services. **Molina Healthcare of Michigan**'s provider data matched the online provider directory; however, the directory information was not confirmed by the provider's office staff members. HSAG recommends that **Molina Healthcare of Michigan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect specialty information) to address the provider data deficiencies. • Of cases in which the survey respondent reported that the provider location accepted **Molina Healthcare of Michigan**, MI Medicaid, and new patients, 71.7 percent of cases offered the caller an appointment date. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Additionally, the low rate of locations offering OB/GYN services (i.e., 29.1 percent) inhibited the callers' ability to survey appointment availability, with only seven OB/GYN cases reaching the appointment availability question within the survey. In addition to using the case-level analytic data files to correct provider data deficiencies, HSAG recommends that **Molina Healthcare of Michigan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Molina Healthcare of Michigan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Molina identified inconsistencies with receiving provider information and began a review of its internal process including roster reconciliation practices, provider audits/secret shopper calls, and validation of the provider data received. Molina took several steps to correct the issue: • Requesting updated provider rosters from all provider groups to ensure the most current information is included in the provider directory. This is an on-going process with these groups and includes an annual attestation from the provider group that they have provided the most accurate information. • Policies were updated to ensure staff was properly trained on the importance of provider directory data collection and ongoing internal audits and secret shopper calls. • Monitoring program was enhanced to include regular audits and secret shopper calls to provider offices. Provider Services Reps also include requests for updated information and staffing changes in their monthly rounding calls.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Molina continues to conduct provider directory audits, secret shopper calls and regular outreach to providers to ensure updated information is sent on a timely basis so the provider directly remains current. In addition, Molina is working with a vendor Hi-Labs to complete verification of provider data accuracy which will support and improve provider data deficiencies, project is expected to be implemented across all lines of business before the end of 2023.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
c. Identify any barriers to implementing initiatives: • Molina continues to work with large provider groups to obtain timely updates. However, the most significant barrier impacting the implementation is the human component from provider compliance to practice/provider staff bandwidth & priorities
HSAG Assessment: HSAG has determined that **Molina Healthcare of Michigan** addressed the prior year's recommendation, as noted through its monitoring and validation efforts. However, the MHP should continue these efforts to ensure members have accurate information available to make appointments and to ensure any barriers to accessing care are mitigated.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG recommended the following: **Adult and Child Medicaid** • **Molina Healthcare of Michigan**'s 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often.* When compared to national benchmarks, parents/caretakers of child members enrolled in **Molina Healthcare of Michigan** had less positive overall experiences with their child's health plan, health care, personal doctor, and specialist. HSAG recommends that **Molina Healthcare of Michigan** continue to explore what may be impacting the drivers of these lower experience scores, develop initiatives designed to improve quality of care, and focus on improving members' overall experiences with their healthcare. **Molina Healthcare of Michigan** should determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the plan that could be contributing to a lack of network adequacy and access issues. **CSHCS** • HSAG recommends that **Molina Healthcare of Michigan** monitor the measures to ensure significant decreases in scores over time do not occur. **HMP** • **Molina Healthcare of Michigan**'s 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, *Getting Needed Care*. When compared to national benchmarks, the results indicate that **Molina Healthcare of Michigan**'s members are reporting more negative experiences with getting the care, tests, treatment, and specialist appointments they need. HSAG recommends that **Molina Healthcare of Michigan** continue to explore what may be the drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, **Molina Healthcare of Michigan** should identify any barriers to accessing healthcare (e.g., transportation, geography) and work toward removing these barriers, so members have better access to care.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Child Medicaid • Initiatives to improve *Rating of Health Plan, Rating of All Health Care and Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*:

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
• Communications are sent by mail, email and text message to familiarize parents & guardians with the survey, anticipate a possible survey in the mail, and encourage them to complete and return the survey. • The health plan created CAHPS Tip Sheets to share with medical providers which provide examples of ways to improve patient satisfaction. • Parents and guardians received reminders to take their children to well care visits which include age-appropriate discussion topics to cover during the visit. CSHCS • Molina hired three additional full-time employees (FTEs) to assist with case management needs of our CSHCS members. • Molina collaborates with the Local Health Departments on CSHCS members to coordinate care and reduce member abrasion and duplication of efforts. HMP • *Getting Needed Care*: Molina's internal team conducts outreach to all HMP members initially and annually to assist with getting the care needed by offering scheduling and transportation assistance, completion of the Health Risk Assessment tool, and identifying healthy behaviors. Molina's Health Educators provide tools, education, and resources for meeting the identified healthy behavior goals as well.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Child CAHPS response rate improved from 14.15% (RY 2022) to 16.70% (RY 2023). o *Rating of Health Plan*: The CAHPS RY 2022 performance rate of 63.30% improved by 7.75 percentage points (CAHPS RY2023 71.05%) o *Rating of Personal Doctor*: The CAHPS RY 2022 rate of 68.50% improved by 6.15 percentage points (CAHPS RY2023 74.65%) o *Rating of Specialist Seen Most Often*: The CAHPS RY 2022 rate of 57.40% improved by 13.51 percentage points (CAHPS RY 2023 70.91%)
c. Identify any barriers to implementing initiatives: • There are no barriers to implementing the initiatives listed above.
HSAG Assessment: HSAG has determined that **Molina Healthcare of Michigan** has partially addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **Molina Healthcare of Michigan**'s scores for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* were all comparable to the 2022 NCQA child Medicaid national average for the child Medicaid population. The score for *Not Felt Treated Unfairly: Health Insurance Type* for the CSHCS population was statistically significantly lower than the 2022 top-box score. The score for *Getting Needed Care* for the HMP population was comparable to the 2022 NCQA adult Medicaid national average and statistically significantly higher than the 2022 score. However, **Molina Healthcare of Michigan** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **Molina Healthcare of Michigan** continue to implement performance improvement interventions and evaluate their effectiveness.

Priority Health Choice

Table 4-7—Prior Year Recommendations and Responses for PRI

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although there were no identified weaknesses, HSAG recommends **Priority Health Choice** use appropriate causal/barrier analysis methods to identify barriers to care and initiate interventions to address those barriers in a timely manner.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Even though no weakness were identified. Priority Health conducted a casual/barrier analysis to identify barriers to care. Subject Matter Experts (SMEs) from across the organization came together to identify barriers. The fish bone diagram was completed during discussions with SMEs, see below. [Fish bone diagram redacted from report due to 508 compliance requirements (i.e., alt text not provided).]
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • By meeting with SMEs and conducting the barrier analysis, Priority Health was able to align initiatives with our barriers to attempt to improve our Prenatal Care rates for African American women.
c. Identify any barriers to implementing initiatives: • N/A.
HSAG Assessment: HSAG has determined that **Priority Health Choice** addressed the prior year's recommendation. The MHP revisited its causal/barrier analysis to identify barriers to care and developed targeted intervention strategies.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **Priority Health Choice**'s performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. HSAG recommends that **Priority Health Choice** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Priority Health Choice** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. • **Priority Health Choice**'s performance for the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* measure indicator ranked between the 25th percentile and 49th percentile, indicating some members with diabetes did not receive kidney health evaluations. HSAG recommends that **Priority Health**

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
Choice conduct a root cause analysis or focused study to determine why some members with diabetes were not receiving kidney health evaluations. Upon identification of a root cause, **Priority Health Choice** should implement appropriate interventions to improve the performance related to the *Kidney Health Evaluation for Patients With Diabetes* measure.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

Priority Health is dedicated to improving our well-child visits and kidney health evaluation rates. The following initiatives are in place to attempt to increase well-child visits (15 to 30 months):

- Member Outreach:
  - Member newsletter includes well-child reminders
  - Next Best Action: Reminder notification via email or letter to members
  - Pfizer partnership: Send out mailings and conduct phone calls to members
- Provider Outreach:
  - Provider Newsletter: Preventative screening requirements have been added to the provider newsletter
  - Provider Virtual Office Advisory (VOA): Live or recorded quality program updates shared with providers
  - Provider HEDIS Guide: Providers have the HEDIS guide available to ensure they understand the requirements of the measure
- Community Outreach:
  - Health Net: Partnership focuses on pediatric preventative screening reminders for members, family support, and provider engagement in Kent County
  - Health Families of America-Wayne: Pursing a partnership that allows us to conduct direct referrals for pregnant members that will be followed until the child is 36 months. They help with scheduling appointments, track vaccinations from birth, conduct home visits to ensure well-child visits and vaccinations are completed
  - Brilliant Detroit: Focused on building healthy neighborhoods for families and children. Priority Health participates in their baby showers as well as community talks to bring awareness to preventative screenings
  - Matrix Human Services: Focus on serving the most vulnerable population in the metropolitan Detroit community, empowering families to enhance their quality of life. Priority Health also attends their community talks to bring awareness
  - Cradle Kalamazoo: In discussions with Cradle Kalamazoo to identify how we can partner to increase compliance on well-child visits

Well-Child (15-30 months) fish bone diagram can be found below:

[Fish bone diagram redacted from report due to 508 compliance requirements (i.e., alt text not provided).]

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures

The following initiatives are in place for kidney health evaluation:
• Member Outreach:
  ○ Conduct outreach to members that haven't received an evaluation
  ○ Include kidney health information in the member newsletter
  ○ Sending A1c at-home kits to members who haven't received a screening in hopes to bring awareness to diabetic testing and understanding
  ○ Care Management supports members with diabetes with resources, diabetic programs, and community support
  ○ Diabetes prevention program: Program is offered to members that are pre-diabetic or might be eligible to participate based on program eligibility requirements
• Provider Outreach:
  ○ Provider Newsletter: Providing education on the importance of kidney evaluation and reminding providers both tests are needed in order to be compliant with the measure
  ○ Provider VOA: Priority Health will be sharing kidney health education with our providers in quarter four (4) of 2023
• Community Partnerships:
  ○ National Kidney Foundation: Priority Health has been in discussion with the National Kidney Foundation to identify how we can better collaborate. The National Kidney Foundation provider resources are included in the Provider newsletter
  ○ MSU partnership: Partnership has been set up for free nutrition classes for Priority Health members. Priority Health is identifying what is the best way to communicate this resource to our members
  ○ Wayne Mobile Unit: Priority Health is discussing kidney health testing with Wayne Mobile Unit to identify areas of collaboration
 	
Kidney Health Evaluation fish bone diagram can be found below:
 	
[Fish bone diagram redacted from report due to 508 compliance requirements (i.e., alt text not provided)]

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
 	
Priority Health tracks measure performance monthly and yearly to identify areas of improvement. In Measurement Year (MY) 2022, the well-child rate (15-30 months) was 59.86%. The well-child 15-30 months rate did not increase from MY2021 to MY2022, with a decrease of 5.72 percentage points.
• Well-Child (15 to 30 months):
  ○ MY2021: 65.58%
  ○ MY2022: 59.86%
• Priority Health will continue to focus on childhood measures to attempt to increase compliance with well-child visits, lead screenings, and immunizations.
 	
From MY2021 to MY2022, the Kidney Health Evaluation for People with Diabetes-Total measure increased by 1.51 percentage point.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures

- Kidney Health Evaluation for People with Diabetes- Total:
  - MY2021: 34.79%
  - MY2022: 36.30%
- Performance by age is demonstrated below. The MY2022 rate for ages 75-85 saw a significant increase when compared to MY2021, 11.63 percentage points. All age groups saw an increase when comparing MY2022 to MY2021.

Kidney Health Evaluation				
Age	18-64	65-74	75-85	Total
MY2021	34.91%	34.09%	29.77%	34.79%
MY2022	35.93%	39.29%	41.40%	36.20%

c. Identify any barriers to implementing initiatives:

- Unable to reach members, demographic information not updated with health plan
- Provider capacity, limited staff, and hours of operations
- Unengaged members
- Family/member might have SDOH needs that need to be resolved before they can address their health needs

HSAG Assessment: HSAG has determined that **Priority Health Choice** has partially addressed the prior year's recommendations. **Priority Health Choice** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator by conducting member outreach using various methods, distributing a provider newsletter that included preventive screening requirements, and developing partnerships with various community agencies. However, **Priority Health Choice** continues to demonstrate low performance for the measure indicator, with the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator ranking below the 25th percentile for MY 2022. HSAG recommends continued efforts by **Priority Health Choice** to improve performance for the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator and monitoring of initiatives currently in place to ensure continued improved performance.

HSAG has determined that **Priority Health Choice** addressed the prior year's recommendation for the *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* measure indicator. **Priority Health Choice** conducted a root cause analysis to determine why some members with diabetes did not receive kidney health evaluations and implemented initiatives such as conducting member outreach using various methods, sending at-home HbA1c tests to members, offering a diabetes prevention program, sending provider newsletters, giving provider education, and developing partnerships with various community agencies. Additionally, the rate increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Priority Health Choice** scored below the statewide average in the Member standard. The MHP received a *Not Met* score for element *3.12 Pregnant Women Dental Policies and Procedures*. As **Priority Health Choice** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **Priority Health Choice** ensure its CAP is fully implemented to mitigate the deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Corrective action was required related to the recently extended post-partum timeframe for PWD [Pregnant Women Dental] eligibility being incorrect in a policy submitted for compliance review. To prevent administrative errors such as this going forward, PRI audits mid-year contract updates, such as this change for PWD against the annual Compliance Review Timeline Tool to identify any items that may be impacted by recent contract changes. If any compliance review criteria appear to be impacted by new requirements, PRI reaches out to MDHHS as needed for clarification of compliance review criteria.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A. There has been no further noncompliance related to mid-year Medicaid contract changes.
c. Identify any barriers to implementing initiatives: • PRI has not identified any barriers to implementing corrective action to mitigate administrative errors related to mid-year contract changes.
HSAG Assessment: HSAG has determined that **Priority Health Choice** addressed the prior year's recommendation. The SFY 2023 compliance review activity confirmed that **Priority Health Choice** received a *Met* score for element 3.12

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • Only 60.5 percent of the sampled provider locations had a matching telephone number when conducting the PDV component of the NVS. **Priority Health Choice**'s provider data included invalid telephone information. HSAG recommends that **Priority Health Choice** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies. • Only 52.7 percent of the sampled provider locations were able to be reached. In addition to the limitations related to the secret shopper approach, **Priority Health Choice**'s provider data included invalid telephone information. While HSAG only contacted locations with matching phone numbers in the online provider directory, the PDV review indicated only 60.5 percent of **Priority Health Choice**'s provider phone numbers provided in the provider data were a match to the online directory. HSAG recommends that **Priority Health Choice** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies. • Of cases reached, only 57.3 percent indicated the office provided the specialty services requested. **Priority Health Choice**'s provider data included invalid specialty information. HSAG recommends that **Priority**

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
Health Choice use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., records with incorrect specialty information) to address the provider data deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: The following initiatives have been implemented in an effort to improve accuracy of provider directory data: • Priority Health continues to pursue direct consumption of data for accepting new MA [undefined acronym] patients. • Priority Health to reinforce provider contractual obligations around data accuracy and terminate practitioners from our network for non-compliance with their contract. • Process to improve the data in the 4275 file is still in effect. Priority Health updated the data crosswalks between Priority Health systems and created an internal audit dashboard to monitor any data gaps, using a program called Ultrix to better manage the provider data. • All new enrollment requests and provider changes are now submitted via the system, Prism. Prism offers direct messaging and visibility to providers or their office staff about the status of their request, including whether any additional information is needed to complete the request. Prism resources are easily accessible to providers and office staff on priorityhealth.com. • We continue to conduct refresher training for our Provider Operations team. Training documents are accessible to staff and specific audit results are shared with team members on an individual basis and tracked in a Quality Dashboard. • Priority Health partnered with Quest Analytics' BetterDoctor Exchange and effective October 2022, BetterDoctor conducts outreach to Priority Health practitioners to ensure our provider directory is as accurate as possible. BetterDoctor uses effective multimodal outreach methods to validate data from each provider (fax, email, phone). Providers validate and update their data via their input into the BetterDoctor portal and the validated data is reviewed and exported back to Priority Health to update our systems.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of utilizing monitoring reports through CAQH Proview and Direct Assure, we were able to identify several providers who were deceased, retired, or left the provider group. Our provider data systems were then updated to reflect these changes.
c. Identify any barriers to implementing initiatives: • Getting providers to attest to Better Doctor when outreach is initiated and timely submission of changes to Priority Health, including demographic updates and open/closed status.
HSAG Assessment: HSAG has determined that **Priority Health Choice** addressed the prior year's recommendation, as noted through its monitoring and validation efforts. However, the MHP should continue these efforts to ensure members have accurate information available to make appointments and to ensure any barriers to accessing care are mitigated.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG recommended the following: **Adult and Child Medicaid** • HSAG recommends that **Priority Health Choice** monitor the measures to ensure significant decreases in scores over time do not occur. **CSHCS** • HSAG recommends that **Priority Health Choice** monitor the measures to ensure significant decreases in scores over time do not occur. **HMP** • HSAG recommends that **Priority Health Choice** monitor the measures to ensure significant decreases in scores over time do not occur.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Priority Health closely monitors our CAHPS scores to determine areas members and providers are not satisfied with. The Quality Improvement team hosts a CAHPS workgroup with key stakeholders from around the organization to help bring awareness to CAHPS, CAHPS results, and brainstorming interventions to implement. The Quality Improvement team monitors performance for Adult and Child, CSHCS, Healthy MI and dental surveys. Priority Health is able to track CAHPS performance year over year and for the adult survey can work with SPH Analytics to request custom reports for additional data evaluation. CAHPS results are also presented at our Consumer Advisor Council to gain more insight from Priority Health members. The Quality Improvement team also shares CAHPS results with our provider network to ensure they are aware of the results. Priority Health conducts Customer Satisfaction surveys (Customer Effort Score) year-round to understand how our members feel about the health plan and identify trends to barriers they might be experiencing. Overall satisfaction from our Customer Effort Score is demonstrated below. Priority Health has an entire team that focuses on customer experience and engagement. [Figure redacted from report due to 508 compliance requirements (i.e., alt text not provided).]
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Priority Health has identified areas of improvement for our CAHPS scores for 2023. Results have been communicated to the CAHPS workgroup and a strategy has been put in place to help increase member and provider satisfaction. Priority Health is also looking at ways to increase response rates for our surveys.
c. Identify any barriers to implementing initiatives: • The CAHPS survey is anonymous which makes it hard for the health plan to identify those members that were not satisfied with the services they received to attempt to eliminate barriers for the member • Members are randomly selected to participate in the survey, Priority Health is unable to follow-up with any member that might have not given the health plan a positive score • Low response rate for adult survey • Survey length

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG Assessment: HSAG has determined that **Priority Health Choice** has partially addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **Priority Health Choice**'s score for *Rating of Specialist Seen Most Often* for the adult Medicaid population was statistically significantly lower than the 2022 top-box score. Furthermore, **Priority Health Choice**'s score for *Customer Service* for the CSHCS population was statistically significantly lower than the 2022 top-box score. However, **Priority Health Choice** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **Priority Health Choice** continue to implement performance improvement interventions and evaluate their effectiveness.

UnitedHealthcare Community Plan

Table 4-8—Prior Year Recommendations and Responses for UNI

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although no weaknesses were identified, HSAG recommends **UnitedHealthcare Community Plan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For the Performance Improvement Plan (PIP) to address disparities in the Timeliness of Prenatal Care, UNI reviewed the casual/barrier analysis. Barriers identified in 2022 continue to be barriers and UNI did not identify additional barriers. Interventions include: Referral of every pregnant member to a Maternal Infant Health Plan (MIHP); Incentives for pregnant members utilizing Babyscripts who attend prenatal appointments; Enrolling rising risk Black, Indigenous, and People of Color (BiPOC) pregnant women in case management; Promoting cultural competency for providers; Promoting the availability and use of Doulas; and, Implementation of Mommy Coach-Perinatal Community Health Workers to plan and choose the model of prenatal that best fits their needs.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • From 2021 to 2022, there was a significant increase in the number of providers in Region 10 completing cultural competency training.
c. Identify any barriers to implementing initiatives: • A barrier for implementing the Doula program was increasing capacity for newly approved policy.
HSAG Assessment: HSAG has determined that **UnitedHealthcare Community Plan** addressed the prior year's recommendation. The MHP revisited its causal/barrier analysis and concluded that no new barriers to care exist for the prenatal care PIP topic.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **UnitedHealthcare Community Plan**'s performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked below the 25th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. HSAG recommends that **UnitedHealthcare Community Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **UnitedHealthcare Community Plan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. • **UnitedHealthcare Community Plan**'s performance for the *Cervical Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women were not always being screened for

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
cervical cancer. HSAG recommends that **UnitedHealthcare Community Plan** conduct a root cause analysis or focused study to determine why some women were not being screened for cervical cancer. Upon identification of a root cause, **UnitedHealthcare Community Plan** should implement appropriate interventions to improve the performance related to the *Cervical Cancer Screening* measure. • **UnitedHealthcare Community Plan**'s performance for the *Breast Cancer Screening* measure ranked between the 25th percentile and 49th percentile, indicating women 50 to 74 years of age were not always being screened for breast cancer. HSAG recommends that **UnitedHealthcare Community Plan** conduct a root cause analysis or focused study to determine why some women were not being screened for breast cancer. Upon identification of a root cause, **UnitedHealthcare Community Plan** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Measure #1 - First 30 Months of Life-Well-Child Visits for Age 15 Months to 30 Months (Two or More Visits). UNI conducted a root cause analysis (RCA) for Well-Child Visits (WCV) and implemented interventions based on the analysis. Interventions involve consistent provider communication channels regarding best practices and resources, including information regarding maximizing sick day visits. Additional provider communication includes newsletters, fax blasts, and direct quality staff contact with gaps in care reports. UNI offers provider incentives for meeting the recommended visits and additional support for low-performing, high volume practices including co-branded letters to encourage member engagement. Co-branded letters to members highlight the importance of well visits, encourage appointment scheduling, and offer transportation assistance to address identified Social Determinants of Health (SDoH) needs. Member communication channels include direct telephonic outreach with appointment assistance, text messaging, and email reminders. Furthermore, UNI provides all members with a live birth information regarding the importance of well-child visits for developmental screenings. • Measure #2 – Cervical Cancer Screening (CCS). UNI conducted a n RCA for CCS and implemented appropriate interventions to improve performance. Interventions include direct quality staff contact with gaps in care reports for providers. UNI offers provider incentives for completion of CCS. There is additional support for low-performing, high volume practices including co-branded letters to encourage member engagement. Co-branded letters to members highlight the importance of CCS and offers transportation assistance to address identified SDoH needs. Member communication channels include direct telephonic outreach with appointment assistance, text messaging, and email reminders. Additionally, UNI provides health information regarding risk factors and the importance of women's health screenings. • Measure #3 – Breast Cancer Screening (BCS). UNI conducted an RCA for BCS and implemented appropriate interventions to improve performance. To improve access and engagement, interventions include collaborative partnerships with mobile mammography units to offer care closer to where members reside. UNI conducts member outreach to assist providers with coordinating breast cancer screening appointments. Based on the members identified needs, UNI also assists members with transportation and/or interpreter services. UNI continues to offer consistent provider communication channels including newsletters, fax blast, and direct quality staff contact with gaps in care reports.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
Additional support for low-performing, high volume practices with co-branded letters has been implemented to encourage member engagement. UNI also encourages engagement by offering both provider and member incentives for BCS.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • UNI tracks and trends performance for measures #1-3. From measurement year 2021 to 2022, UNI noted the following: • Measure #1 - First 30 Months of Life-Well-Child Visits for Age 15 Months to 30 Months (Two or More Visits) improved by 2.46% from 58.08% to 60.54%. UNI will continue to implement continuous quality improvement initiatives and incorporate interventions into our routine processes. • Measure #2 - Cervical Cancer Screening remained at 58.88%. UNI will continue to monitor CCS and implement continuous quality improvement initiatives. UNI continues to advance initiatives to support CCS. • Measure #3 - Breast Cancer Screening improved by 2.3% from 51.15% to 53.45%. Collaborative partnerships were successful, and UNI continues to expand and incorporate interventions into routine health plan processes.
c. Identify any barriers to implementing initiatives: • Measure #1 - No barriers identified. • Measure #2 - Improved performance has yet to be demonstrated. Interventions are being targeted to this measure and performance will be monitored quarterly. • Measure #3 - No barriers identified
HSAG Assessment: HSAG has determined that **UnitedHealthcare Community Plan** has partially addressed the prior year's recommendations. **UnitedHealthcare Community Plan** has put forth effort to address HSAG's prior year recommendation for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator by giving provider incentives for meeting the recommended visits, providing additional support for low-performing providers, and offering transportation assistance to address identified SDOH needs. While the measure indicator rate significantly increased from the prior year, **UnitedHealthcare Community Plan** continues to demonstrate low performance for the measure indicator, with the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator ranking between the 25th and 49th percentile for MY 2022. HSAG recommends continued efforts by **UnitedHealthcare Community Plan** to improve performance for the *Well-Child Visits in the First 15 Months—Two or More Well-Child Visits* measure indicator and monitoring of initiatives currently in place to ensure continued improved performance. HSAG has determined that **UnitedHealthcare Community Plan** addressed the prior year's recommendation for the *Cervical Cancer Screening* measure. **UnitedHealthcare Community Plan** conducted a root cause analysis to determine why some women were not always being screened for cervical cancer and implemented initiatives such as providing gaps-in-care reports to providers, conducting member outreach using various methods, offering provider incentives for completion of screenings, providing additional support for low-performing providers, providing member education, sending letters to members regarding the importance of screenings, and offering transportation assistance to members in need. Additionally, the rate increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
HSAG has determined that **UnitedHealthcare Community Plan** addressed the prior year's recommendation for the *Breast Cancer Screening* measure. **UnitedHealthcare Community Plan** conducted a root cause analysis to determine why some women were not always being screened for breast cancer and implemented initiatives such as having collaborative partnerships with mobile mammography units to offer care closer to member residences, conducting member outreach, assisting providers with coordinating breast cancer screening appointments, assisting members with transportation and/or interpreter services, providing gaps-in-care reports to providers, providing additional support for low-performing providers, and offering both provider and member incentives for screenings. Additionally, the rate significantly increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **UnitedHealthcare Community Plan** scored below the statewide average in the Provider standard. The MHP received a *Not Met* score for elements *2.7 Provider Network–MHP Demonstrates that Covered Services are Available and Accessible*, *2.20 Credentialing and Recredentialing Policies*, and *2.21 Secret Shopper Calls*. As **UnitedHealthcare Community Plan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **UnitedHealthcare Community Plan** ensure its CAP is fully implemented to mitigate the deficiencies. • **UnitedHealthcare Community Plan** scored below the statewide average in the Quality standard. The MHP received a *Not Met* score for element *4.9 PMR Review*. As **UnitedHealthcare Community Plan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **UnitedHealthcare Community Plan** ensure its CAP is fully implemented to mitigate the deficiencies. • **UnitedHealthcare Community Plan** scored below the statewide average in the MIS standard. The MHP received a *Not Met* score for elements *5.6 Pharmacy/MCO Common Formulary* and *5.8 Third Party Subrogation Requests* (the MHP was cited twice for element 5.8). As **UnitedHealthcare Community Plan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **UnitedHealthcare Community Plan** ensure its CAP is fully implemented to mitigate the deficiencies. • **UnitedHealthcare Community Plan** scored below the statewide average in the Program Integrity standard. The MHP received a *Not Met* score for elements *6.1 Quarterly Program Integrity Forms–Tips and Grievances*, *6.2 Quarterly Program Integrity Forms–Data Mining*, *6.3 Quarterly Program Integrity Forms–Audits*, and *6.4 Quarterly Program Integrity Forms–Provider Disenrollments*. As **UnitedHealthcare Community Plan** previously submitted a CAP to address these findings which was approved by MDHHS, HSAG recommends **UnitedHealthcare Community Plan** ensure its CAP is fully implemented to mitigate the deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: 2.7 Provider Network–MHP Demonstrates that Covered Services are Available and Accessible • UnitedHealthcare has processes in place to monitor our network monthly by running new GEO reports to ensure network adequacy per our state contract. For any Provider Types/Counties that do not meet

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
time, distance or ratio standards, a Provider Network Exception request will be submitted to Michigan Department of Health and Human Services (MDHHS) within 10 business days of the network change that caused the need for an exception (or is submitted with Compliance Review submissions) • Further, while UNI's network is adequate and accessible to all members and positioned for growth, UnitedHealthcare continues to attempt to negotiate agreements with non-contracted providers to expand UNI's network as much as possible. These are ongoing efforts. 2.20 Credentialing and Recredentialing Policies • UnitedHealthcare by mistake, neglected to include the policies and procedures for 2.20 in the zip file submission on 6.15.22. As a result of this error, a process was implemented to ensure a complete audit of all deliverables is completed prior to uploading the submission. 2.21 Secret Shopper Calls • Every provider in the UnitedHealthcare (UNI) network will be included in a provider validation audit. The audit will be conducted as follows: o Validate information received via CAQH and My Practice profile where providers attest to their data every 180 days. o Utilize auto dialer to validate providers have active phone numbers and provide remediation efforts where they do not. o Providers that do not fall into the roster cleanse, attestation or auto dialer, we will perform an outreach campaign to validate provider information. o Delegated Roster audits. 4.9 PMR Review-Low Birth Weight (LBW) • For the August 9, 2022, Corrective Action Plan on element 4.9 PMR review, UNI implemented the following interventions to help reduce LBW among our members: Healthy First Steps (HFS), a Doula Pilot Program, the Michigan Child Perinatal Collaborative Care / High Touch, High Tech (MC3/HT2), as well as the Mommy Coach Program which is now referred to as the Perinatal Community Health Worker (CHW) program. • HFS Modernization connects pregnant women to our case management program designed for engagement and interventions across risk tiers. This is a team-based model of care which focuses on utilizing teams to best support the member's unique set of needs and to accomplish shared goals within and across settings to achieve coordinated high-quality care. In addition, there are specific CHW interventions for the Black, Indigenous, and People of Color (BiPOC) population to reduce disparities. The HFS interventions are still underway and continue to support improving our health plan's LBW. • The Doula Pilot Program was an intervention to assist birth outcomes for women by providing doula support. However, all Michigan Medicaid women now have access to utilizing doulas as a covered benefit, so this pilot is no longer needed. We will continue to provide doulas to all women who so desire these services as part of their birth plan. • The MC3/HT2 perinatal program offers no cost psychiatry support to perinatal providers and members through same day phone consultations to offer guidance to diagnostic questions, safe medications, and appropriate psychotherapy. The program and interventions are still ongoing. • Lastly, the Perinatal CHW program focuses on providing care to African American members residing in Detroit. This program is a model of care with the goal to help and support women in creating a birth plan, selecting their pre/post-natal delivery team, and assisting in SDoH needs. Additionally, the CHWs assess members' experience of respect provided by their maternity healthcare providers, as well

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
as measure women's autonomy and role in decision-making. The Perinatal CHW program is still underway. 4.9 PMR Review-HMP Dental • For the Corrective Action Plan on the percentage of Healthy Michigan Plan (HMP) members between the ages of 19 and 64 who received at least one diagnostic dental service within the measurement period or at least one preventive dental service or at least one restorative dental service, element 4.9 PMR review, UNI implemented the following interventions to help increase dental utilization: Created a separate dental member ID card, increased the number of dental reminder post cards that UNI mails out on a monthly basis, and increased CHW outreach to members who have not been to a dentist in 24 months. The following activities are still underway: Dental homes, member and provider incentives, VBC provider contracts, and allowing out-of-network benefits. 4.9 Diagnostic Dental for Pregnant Members • UNI interventions for pregnant members include all interventions described for HMP Dental. In addition, UNI promotes dental health for pregnant members within UNI's new Welcome Kit, which includes a Getting Started Guide, the HFS program, and CHW outreach assistance. 4.9 Lead Screening in Children (LSC) • Interventions include collaborative partnerships with grants for participating Federally Qualified Healthcare Centers (FQHCs) to increase screening capacity. Direct quality staff contact with gaps in care reports for providers. There is additional support for low-performing, high volume practices including co-branded letters to encourage member engagement, highlight the benefits of LSC, and offer transportation assistance to address identified SDoH. Member communication channels include direct telephonic outreach with appointment assistance, text messaging, and email reminders. UNI offers both provider and member incentives for completion of LSC. 4.9 Developmental Screening in Children • UNI interventions to improve Developmental Screening in Children consist of member outreach to improve awareness about the importance of developmental screenings and timeframes, including outreach to postpartum members. UNI continues to offer consistent provider communication channels including newsletters, fax blast, and quality staff contact. Furthermore, communication channels are utilized to educate providers regarding both correct billing codes and available screening tools. 4.9 Breast Cancer Screening (BCS) • To improve access and engagement, interventions include collaborative partnerships with mobile mammography units to offer care closer to where members reside. UNI conducts member outreach to assist providers with coordinating BCS appointments. Based on the members identified social needs, UNI assists members with transportation and/or interpreter services. UNI continues to offer consistent provider communication channels, including newsletters, fax blast, and direct quality staff contact with gaps in care reports. Additional support for low-performing, high volume practices with co-branded letters are provided to encourage member engagement. UNI also encourages engagement by offering both provider and member incentives for BCS. 5.6 Pharmacy/MCO Common Formulary • For the 2022 Compliance Review, UNI exceeded the compliance ratio of 0.1% for claim denial with NCPDP Reject Code 70. The primary cause was due to auto drug file changing status of a medication's multi-source code (MSC) and not being detected. For corrective action, UNI took 5 courses of action:

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
○ Initial Review of All Claims: A review of all claims that used NCPDP Reject 70 to identify any additional medications that is using NCPDP Reject Code 75 inappropriately. ○ Issue of Drug File updates disrupting Brand-Over-Generic Strategy: Corrective action requires manual review of the weekly file updates by a dedicated team to ensure any change to MSC status does not disrupt strategy. ○ Internal Formulary strategy: UNI updated the coding strategy that will manage the drug benefit at the NDC level. Moving to this strategy, non-preferred medications will default to reject with NCPDP reject code 75. ○ Enhanced Review of MPPL: MPPL provides listing of new, coverable medications. Part of this monthly review will make certain that these medications align with UNI's formulary strategy. ○ Routine pharmacy claims audits to confirm compliance with measure throughout remainder of 2022 to provide confidence in resolving matter. Going forward, random audits are performed. 5.8 Third Party Subrogation Requests • Additional quality checks were implemented to ensure the final state ready report includes all appropriate information for submission to the state. Additionally, weekly reviews on Michigan cases were implemented to reduce risk of cases exceeding the 30-day response requirement. These quality checks were updated in internal processing documentation and training was provided to those involved with report creation. 6.1-6.4 Quarterly Program Integrity Forms-Tips and Grievances, Data Mining, Audits and Overpayments • The UnitedHealthcare Community Plan Compliance officer and the reporting analyst met with all data owners that supply information to the reporting template to discuss the cited deficiencies. During the meeting, it was discovered that human error was to blame for the deficiencies. All data owners were provided with a copy of the OIG report guidelines to help ensure that the data is reported correctly.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): 2.20 Credentialing and Recredentialing Policies • Year to date, the health plan has not received any corrective action plans as a result of information missing from the audit submission. 4.9 PMR Review-Low Birth Weight • In April 2022, the performance monitoring report (PMR) showed a LBW rate for UNI at 10%. In July 2023, the PMR reported an LBW rate for UNI at 9.77%. UNI continues to strive towards decreasing the LBW rate to achieve the state goal of under 8%. UNI believes the various interventions are aiding in LBW rate improvements. • Specifically, for the members enrolled in HFS during the July 2022 to present timeframe, the LBW rate was 10.1%. UNI has no baseline for comparison for this intervention as it is a new program. UNI continues daily outreach, encourages engagement, and will continue to monitor the results of this initiative. • While UNI was in the process of implementing a doula pilot program, these services became a covered benefit for all women with Medicaid coverage. UNI will continue to track outcomes for pregnant women receiving doula services and provide member education. • UNI continues collaboration with the MC3/HT2 perinatal program. There is no member level detail available for women enrolled in this program, so no birthweight data is available at this time. However, from April 2023 to June 2023, 53 members were referred and of those 42 enrolled with MC3 services. It has shown to decrease Patient Health Questionnaire (PHQ9) depression screening and General

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
Anxiety Disorder-7 (GAD-7) scores for those enrolled and receiving services. In addition, member and provider satisfaction scores are in the high 90's (on a percentage scale of 0-100%). • The Perinatal CHW program continues to implement CHW engagement interventions for women residing in Detroit. Enrollment has been slow to start, with 44 enrolled and 23 delivered. There has been only one member who had an LBW baby or 4% LBW rate. UNI will continue to monitor this program engagement as well as LBW outcomes for this specific population. 4.9 PMR Review-HMP Dental • As of the July 2023 PMR report we have not noticed any performance improvement, however the PMR is measuring utilization prior to us implementing some of the interventions as listed above. 4.9 Diagnostic Dental for Pregnant Members • As of the July 2023 PMR report, we have not noted a performance improvement. However, the PMR is measuring utilization prior to UNI implementing some of the interventions listed above. 4.9 LSC • From measurement year 2021 to 2022, LSC improved by .24% from 58.88% to 59.12%. 4.9 Developmental Screening in Children • From April measurement year 2022 to 2023, Developmental Screening First Year of Life improved by 2.09% from 25.82% to 27.91%. • From April measurement year 2022 to 2023, Developmental Screening Second Year of Life improved by 3.16% from 29.91% to 33.07%. • From April measurement year 2022 to 2023, Developmental Screening Third Year of Life improved by 3.96% from 25.02% to 28.98%. 4.9 BCS • From measurement year 2021 to 2022, BCS improved by 2.3% from 51.15% to 53.45%. 5.6 Pharmacy/MCO Common Formulary o Claims reviewed from 6/20/22 through 6/23/22 calculated a compliance ratio of 0.04% o Follow-up claims review through the remainder of 2022 maintained a compliance ratio of less than 0.1% o For the 5.6 Pharmacy/MCO Common Formulary measure for 2023, we MET the measure by maintaining a less than 0.1% compliance. 5.8 Third Party Subrogation Requests • Year to date, the health plan has not received any corrective action plans for this deliverable.
c. Identify any barriers to implementing initiatives: 2.7 Provider Network–MHP Demonstrates that Covered Services are Available and Accessible • No barriers identified. 2.20 Credentialing and Recredentialing Policies • No barriers identified. 2.21 Secret Shopper Calls • As we conduct the telephonic outreach for these audits, we are encountering office staff that are indicating they do not have time to validate their data. We were offering several options for these practices such as online attestations and faxed validation forms. Some offices are requiring several follow up outreaches to get this completed information.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
4.9 PMR Review-Low Birth Weight • Barriers to both the Perinatal CHW program as well as HFS include engagement with members. Some members have the wrong phone number listed, will not answer their phone, or answer their door. These barriers will continue to be addressed, including efforts in engaging members. • Barriers to the MC3/HT2 perinatal program include difficulty in obtaining member level detail. However, UNI continues to inquire as to a way in obtaining and in the interim will continue to review behavioral health outcomes, which ultimately will improve other clinical outcomes for these pregnant women. 4.9 HMP Dental • Barriers to performance improvement include engagement with members and incorrect address information. Some members have the wrong phone number listed or will not answer their phone. These barriers will continue to be addressed, including efforts in engaging members. 4.9 Diagnostic Dental for Pregnant Members • Barriers to performance improvement include engagement with members and incorrect address information. Some members have the wrong phone number listed or will not answer their phone. These barriers will continue to be addressed, including efforts in engaging members. 4.9 LSC • UNI collaborated with a manufacturer of lead screening point-of-care testing machines to ensure provider clarity and understanding associated with expiration of testing strips and control solutions which was an identified barrier. 4.9 Developmental Screening in Children • No barriers identified. 4.9 BCS • No barriers identified. 5.6 Pharmacy/MCO Common Formulary • No barriers identified. 5.8 Third Party Subrogation Requests • No barriers identified. 6.1-6.4 Quarterly Program Integrity Forms-Tips and Grievances, Data Mining, Audits and Overpayments • No barriers identified.
HSAG Assessment: HSAG has determined that **UnitedHealthcare Community Plan** addressed the prior year's recommendations. The SFY 2023 compliance review activity confirmed that **UnitedHealthcare Community Plan** achieved a *Met* score for elements 2.7, 2.20, 4.9, 5.6, and 5.8. However, although the MHP implemented a process to verify and correct all network providers' provider directory information, the SFY 2023 compliance review activity showed that **UnitedHealthcare Community Plan** received a *Not Met* score for element 2.22. Secret shopper calls demonstrated that PCPs and pediatric PCPs were not generally aware that they had a contract with the MHP and their demographic information and "accepting new patients" status were not always accurate within the provider online directory. HSAG recommends that the MHP continue to conduct outreach to the providers to update the provider online directory information as necessary. Additionally, the SFY 2023 compliance review activity demonstrated that **UnitedHealthcare Community Plan** continued to have deficiencies in elements 6.1, 6.2, 6.3, and 6.4. **UnitedHealthcare Community Plan**'s CAP activities did not appear to have resulted in improved performance. Therefore, HSAG recommends that **UnitedHealthcare Community Plan** implement an oversight process to ensure all program integrity forms are complete and accurate before submission to MDHHS.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • Only 45.5 percent of the sampled provider locations could be reached. In addition to the limitations related to the secret shopper approach, **UnitedHealthcare Community Plan**'s provider data included invalid telephone or address information when contacting the office staff members. HSAG recommends that **UnitedHealthcare Community Plan** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect contact information) to address the provider data deficiencies. • Of cases in which the survey respondent reported that the provider location accepted **UnitedHealthcare Community Plan**, MI Medicaid, and new patients, 66.7 percent of cases offered the caller an appointment. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. Additionally, the low rates of locations offering the requested specialty; being affiliated with the sampled provider; and accepting MHP, MI Medicaid, and new patients inhibited callers' ability to survey appointment availability. Only 27 cases reached the appointment availability question within the survey. In addition to correcting provider data deficiencies. HSAG recommends that **UnitedHealthcare Community Plan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **UnitedHealthcare Community Plan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Every provider in the UnitedHealthcare (UNI) network will be included in a provider validation audit. The audit will be conducted as follows: o Validate information received via CAQH and My Practice profile where providers attest to their data every 180 days. o Utilize auto dialer to validate providers have active phone numbers and provide remediation efforts where they do not o Providers that do not fall into the roster cleanse, attestation or auto dialer, we will perform an outreach campaign to validate provider information. o Delegated Roster audits • These audits have been conducted over the past 5 months. The status of the provider validation audits are as follows: o CAHQ and my Practice profile validations completed and ongoing o Auto-Dialer audits completed o Provider outreach: 1,498 calls remaining o Delegated Roster Audits: ▪ 5 Delegated Rosters audits completed ▪ 8 Delegated Roster audits in process (targeted completion date 10/1)

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
▪ 2 Delegated Rosters not started – working to get a full roster from the provider • As UNI completes these audits, system updates are made at the same time when necessary. • As a part of this audit process, UNI is educating provider office staff on their participation as well as their contractual obligation regarding appointment time frames. This education will continue through advocate outreach and support.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As UNI continue the audit process of our entire network, provider data improvement is on-going.
c. Identify any barriers to implementing initiatives: • As UNI conducts the telephonic outreach for these audits, UNI is encountering office staff that are indicating they do not have time to validate their data. UNI has offered several options for these practices such as online attestations and faxed validation forms. Some offices are requiring several follow up outreaches to get this completed information.
HSAG Assessment: HSAG has determined that **UnitedHealthcare Community Plan** addressed the prior year's recommendations, as noted through its audit and validation efforts. However, the MHP should continue these efforts to ensure members have accurate information available to make appointments and to ensure any barriers to accessing care are mitigated.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG recommended the following: **Adult and Child Medicaid** • **UnitedHealthcare Community Plan**'s 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures: *Rating of All Health Care* and *Getting Care Quickly*. **UnitedHealthcare Community Plan**'s providers may not be providing care to child members as quickly as other providers and parents/caretakers of child members are reporting lower overall experience scores with their child's healthcare. HSAG recommends that **UnitedHealthcare Community Plan** continue to explore the drivers of these lower experience scores and develop initiatives designed to improve quality of care and timeliness of care. **CSHCS** • HSAG recommends that **UnitedHealthcare Community Plan** monitor the measures to ensure significant decreases in scores over time do not occur. **HMP** • HSAG recommends that **UnitedHealthcare Community Plan** monitor the measures to ensure significant decreases in scores over time do not occur.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UNI ensures inclusion of members, parents/caregivers, and community leaders through our Member Advisory Group (MAG) and Community Advisory Committee (CAC). UNI shares Consumer Assessment of Healthcare Providers and Systems (CAHPS) results including the Rating of All Health Care and Getting Care Quickly to engage attendees in open discussions about CAHPS results and solicit meaningful input, recommendations, and feedback.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
• UNI partnered with Press Ganey, an industry leader in patient experience. Through the partnership, providers have access to interactive modules and downloadable guides to assist them with improving the patient experience. Each module focuses on a specific element of the member experience including Rating of All Health Care and Getting Care Quickly. • Direct telephonic assistance from CHWs to support members and parents/caregivers with getting care, education on benefits, and connecting with community-based, non-clinical resources to improve social need barriers potentially impacting the members' experience.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • From 2022 to 2023, UNI's child member experience in "Rating of All Health Care" improved by 5.70% from 63.87% to 69.57%. UNI will continue to implement continuous quality improvement initiatives including MAG and CAC recommendations. • From 2022 to 2023, UNI's child member experience in "Getting Care quickly" improved by 5.99% from 79.82% to 85.81%. UNI will continue to implement continuous quality improvement initiatives including MAG and CAC recommendations. • UNI is currently waiting for the 2023 HMP CAHPS survey results and will track performance to meet improvement goals.
c. Identify any barriers to implementing initiatives: • Challenge to monitor the impact of process improvement activities with annually available data.
HSAG Assessment: HSAG has determined that **UnitedHealthcare Community Plan** has partially addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **UnitedHealthcare Community Plan**'s scores for *Rating of All Health Care* and *Getting Needed Care Quickly* were comparable to the 2022 NCQA child Medicaid national average for the child Medicaid population. The scores for *How Well Doctors Communicate* and *Not Felt Treated Unfairly: Health Insurance Type* for the CSHCS population were statistically significantly lower than the 2022 top-box score. Furthermore, **UnitedHealthcare Community Plan**'s score for *Getting Needed Care* for the HMP population was statistically significantly lower than the 2022 top-box score. However, **UnitedHealthcare Community Plan** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **UnitedHealthcare Community Plan** continue to implement performance improvement interventions and evaluate their effectiveness.

Upper Peninsula Health Plan

Table 4-9—Prior Year Recommendations and Responses for UPP

1. Prior Year Recommendation From the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Although there were no identified weaknesses, HSAG recommends **Upper Peninsula Health Plan** revisit its causal/barrier analysis to ensure that the barriers identified continue to be barriers and determine if any new barriers exist that require the development of interventions.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UPHP completed a cause-and-effect analysis and reported findings as part of the Performance Improvement Project (PIP) submission. UPHP received 100% for Step 8 of the reporting template, and has revised interventions as needed based on this analysis.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A.
c. Identify any barriers to implementing initiatives: • No barriers noted.
HSAG Assessment: HSAG has determined that **Upper Peninsula Health Plan** addressed the prior year's recommendation. The MHP revisited its causal/barrier analysis to identify barriers to care and developed targeted intervention strategies.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
HSAG recommended the following: • **Upper Peninsula Health Plan**'s performance for all *Chlamydia Screening in Women* measure indicators ranked below the 25th percentile, indicating that women identified as sexually active were not always receiving at least one test for chlamydia during the measurement year. HSAG recommends that **Upper Peninsula Health Plan** conduct a root cause analysis or focused study to determine why some women identified as sexually active did not receive testing for chlamydia. Upon identification of a root cause, **Upper Peninsula Health Plan** should implement appropriate interventions to improve the performance related to the *Chlamydia Screening in Women* measure. • **Upper Peninsula Health Plan**'s performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator ranked between the 25th percentile and 49th percentile, indicating children who turned 30 months old during the measurement year were not always getting at least two well-child visits with a PCP in the last 15 months. HSAG recommends that **Upper Peninsula Health Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Upper Peninsula Health Plan** should implement appropriate interventions to improve the performance related to the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
• **Upper Peninsula Health Plan**'s performance for the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* measure indicator ranked between the 25th percentile and 49th percentile, indicating some children ages 18 to 21 years were not always receiving one or more well-care visit during the measurement year. HSAG recommends that **Upper Peninsula Health Plan** conduct a root cause analysis or focused study to determine why some children did not receive timely well-child visits. Upon identification of a root cause, **Upper Peninsula Health Plan** should implement appropriate interventions to improve the performance related to the *Child and Adolescent Well-Care Visits* measure.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • *Chlamydia Screening in Women*: UPHP root cause analysis noted the following: women ages 16-20 show a disparate rate of screening than the 21-24 age group, providers have noted differences in coverage between payors as a barrier, and minorities are screened at a higher rate than White members. UPHP included Chlamydia screening in the CY23 HEDIS Value Based Payment Alternative Payment Model. A letter was sent to members aged 16-24 years in June 2023 educating members and guardians on the importance of chlamydia screening. • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*: UPHP did not conduct a specific root cause analysis to determine why some children did not receive timely well-child visits, as UPHP performed in the 90th percentile for this measure in MY22. UPHP will continue ongoing interventions for this measure in FY24, which includes various mailings, targeted telephone reminders, and a targeted text messaging campaign. • *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years*: UPHP conducted a root cause analysis in CY22 to determine why some children did not receive timely well-care visits. Root cause analysis shows that members in the 18-21 age group who are transitioning into adulthood may require 1) assistance establishing a new PCP and 2) education on importance of well-care, as this age group is typically healthy, does not require any non-seasonal recommended vaccinations, and does not feel well-care is necessary. UPHP addresses this barrier with a Transition to Adulthood care letter for members turning 18. UPHP also added the WCV measure to the HEDIS Value Based Payment Alternative Payment Model available to all primary care provider clinics. UPHP attended a college fair in August 2023 to promote health & wellness to this age demographic.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • *Chlamydia Screening in Women*: Performance improvement TBD for both the APM and letter. Preliminary rates for Chlamydia Screening in UPHPs HEDIS reporting software show a year-over-year increase for both age groups, 16-20 and 21-24, for August 2023 vs August 2022. Ages 16-20 increased 1.34 percentage points, and ages 21-24 showed an increase of 3.53 percentage points. • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*: UPHP members meeting criteria for W30 – Age 15-30 months increased from 67.43% in MY21 to 68.09% in MY22, a total of 0.66%. • *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years*: UPHP data shows that the WCV rate for 18 to 21 year olds was 23.73 in MY22, which is a 0.29 percent increase from the MY21 rate of 23.44.

2. Prior Year Recommendation From the EQR Technical Report for Validation of Performance Measures
c. Identify any barriers to implementing initiatives: • Chlamydia Screening in Women: None • Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits: Significant delay in text messaging campaign initiation in CY23 due to a variety of factors including internal and external staff turnover for both UPHP and our vendor, competing priorities, and dispute regarding the terms of the vendor contract. • Child and Adolescent Well-Care Visits—Ages 18 to 21 Years: None
HSAG Assessment: HSAG has determined that **Upper Peninsula Health Plan** has partially addressed the prior year's recommendations. **Upper Peninsula Health Plan** has put forth effort to address HSAG's prior year recommendation for the *Chlamydia Screening in Women* measure indicators by conducting a root cause analysis and distributing letters to members ages 16 to 24 years, educating members and guardians on the importance of chlamydia screening. While the *Ages 16 to 20 Years* and *Total* measure indicator rates slightly increased from the prior year, **Upper Peninsula Health Plan** continues to demonstrate low performance for the measure indicators, with all measure indicators ranking below the 25th percentile for MY 2022. HSAG recommends continued efforts by **UnitedHealthcare Community Plan** to improve performance for the *Chlamydia Screening in Women* measure indicators and monitoring of initiatives currently in place to ensure continued improved performance. HSAG has determined that **Upper Peninsula Health Plan** partially addressed the prior year's recommendation for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator. While **Upper Peninsula Health Plan** did not conduct a root cause analysis to determine why some children did not receive timely well-child visits and initiatives will not be implemented until SFY 2024, the rate increased from the prior measurement year and ranked in the 50th to 74th percentile for MY 2022, demonstrating improved performance. To ensure continuous improvement in performance for the measure indicator, HSAG recommends that **Upper Peninsula Health Plan** conduct a root cause analysis to ensure that planned incentives are impactful and address the identified barriers. Regarding HSAG's prior year recommendation for the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* measure indicator, **Upper Peninsula Health Plan** has demonstrated efforts by conducting a root cause analysis, distributing a Transition to Adulthood care letter for members turning 18 years old, adding the measure to the HEDIS Value-Based Payment Alternative Payment Model, and promoting health and wellness at a college fair. While the measure indicator rate for *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* slightly increased from the prior year, **Upper Peninsula Health Plan** continues to demonstrate low performance for the measure indicator by ranking between the 25th and 49th percentile for MY 2022. HSAG therefore recommends that **Upper Peninsula Health Plan** continue its efforts on further improving the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* rate and monitoring the impact of initiatives currently in place to ensure improved performance.

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Upper Peninsula Health Plan** scored below the statewide average in the Provider standard. The MHP received a *Not Met* score for elements *2.7 Provider Network–MHP Demonstrates that Covered Services are Available and Accessible*, *2.10 Provider Wait Times*, *2.16 PBM Service Organization Controls Report*, and *2.21 Secret Shopper Calls*. As **Upper Peninsula Health Plan** previously submitted a CAP to address

3. Prior Year Recommendation From the EQR Technical Report for Compliance Review
these findings which was approved by MDHHS, HSAG recommends **Upper Peninsula Health Plan** ensure its CAP is fully implemented to mitigate the deficiencies.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UPHP developed and implemented an annual process on conducting secret shopper calls to validate provider wait times and information listed in the provider directories. Policy 200-013 Timely Access to Care was updated, and information regarding provider wait time guidelines was provided to providers/provider offices through the Provider Newsletter and presented at the annual UPHP Provider Inservice.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • UPHP received updated information from provider offices regarding provider availability and updated the provider network/directories immediately from the information provided.
c. Identify any barriers to implementing initiatives: • Many offices stated they continue to be short-staffed which result in longer provider wait times for members to receive care.
HSAG Assessment: HSAG has determined that **Upper Peninsula Health Plan** addressed the prior year's recommendations. The SFY 2023 compliance review activity confirmed that **Upper Peninsula Health Plan** achieved a *Met* score for elements 2.7, 2.10 and 2.16. However, although the MHP implemented a process to validate provider wait times and information listed in the provider online directory in relation to element 2.21, the secret shopper results for OB/GYN PCPs continued to show that providers were not aware of their contracts with the MHP and the "accepting new patients" status was not always correct in the provider online directory. HSAG recommends that **Upper Peninsula Health Plan** continue to conduct outreach to the providers to update the provider online directory information as necessary.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • Of cases in which the survey respondent reported that the provider location accepted **Upper Peninsula Health Plan**, MI Medicaid, and new patients, 74.3 percent of cases offered the caller an appointment date. For new members attempting to identify available providers and schedule appointments, procedural barriers to reviewing appointment dates and times represent limitations to accessing care. HSAG noted several common appointment considerations that impacted the number of callers offered an appointment. In addition to using the case-level analytic data files to correct provider data deficiencies, HSAG recommends that **Upper Peninsula Health Plan** work with its contracted providers to ensure sufficient appointment availability for its members. HSAG further recommends that **Upper Peninsula Health Plan** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.

4. Prior Year Recommendation From the EQR Technical Report for Network Adequacy Validation
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UPHP updated the Quarterly Provider Practice Verification process from fax to email. UPHP also implemented and continues to conduct secret shopper calls annually to verify provider wait times and information listed on the provider directory to verify accuracy. UPHP continues to conduct quarterly directory audits on the provider directory, as well as marking PCP providers who work less than 20 hours per week at a location silent to not be listed on the directory. UPHP staff does have access to this information in the event a member requests services from that provider at that location.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • UPHP received an increase in provider offices providing updated provider information when the process was updated to email. This change resulted in more updated information for the provider directory.
c. Identify any barriers to implementing initiatives: • Provider office staff turnover does continue to be a barrier when members reach out requesting appointments. Information and education is provided to the staff from UPHP regarding provider participation and the different lines of business of UPHP insurance.
HSAG Assessment: HSAG has determined that **Upper Peninsula Health Plan** addressed the prior year's recommendations, as noted through its monitoring and validation efforts. However, the MHP should continue these efforts to ensure members have accurate information available to make appointments and to ensure any barriers to accessing care are mitigated.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
HSAG recommended the following: **Adult and Child Medicaid** • HSAG recommends that **Upper Peninsula Health Plan** monitor the measures to ensure significant decreases in scores over time do not occur. **CSHCS** • HSAG recommends that **Upper Peninsula Health Plan** monitor the measures to ensure significant decreases in scores over time do not occur. **HMP** • **Upper Peninsula Health Plan**'s 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*. When compared to national benchmarks, the results indicate that **Upper Peninsula Health Plan** members are reporting a more negative experience with their overall healthcare. HSAG recommends that **Upper Peninsula Health Plan** explore drivers of this lower experience score and develop initiatives designed to improve quality of care, including a focus on improving members' overall experiences with their healthcare.

5. Prior Year Recommendation From the EQR Technical Report for CAHPS
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The UPHP CAHPS Taskforce, a subset of our Service Advisory Committee (SAC), meets routinely throughout the year to work through analyzing CAHPS scores and identifying appropriate actions and initiatives to maintain or improve CAHPS scores. Several initiatives have been implemented aimed at improving the services and coordination within the UPHP Adult and Child Medicaid/CSHCS and HMP provider network. • For HMP along with all activities noted above we are working to improve provider engagement within our network to better understand the challenges they face in delivering quality care and collaborate with them to identify opportunities for improvement. The CAHPS taskforce is currently discussing offering training programs to healthcare providers focused on enhancing patient satisfaction, communication skills, and patient-centered care practices and possibly incentivizing providers to participate in these training programs.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Although it is too early to evaluate initiative success, we have been encouraged at the number of provider offices that that have been interested in other provider trainings coordinated by UPHP.
c. Identify any barriers to implementing initiatives: • We continually have been told by providers that although trainings are beneficial, they find very little time is available throughout their workday to participate in such virtual trainings.
HSAG Assessment: HSAG has determined that **Upper Peninsula Health Plan** has partially addressed the prior year's recommendations. The SFY 2023 CAHPS activity confirmed that **Upper Peninsula Health Plan**'s score for *Rating of All Health Care* for the HMP population was comparable to the 2022 NCQA adult Medicaid national average. **Upper Peninsula Health Plan**'s score for *Rating of Health Plan* for the adult Medicaid population was statistically significantly lower than the 2022 top-box score. Furthermore, **Upper Peninsula Health Plan**'s score for *Rating of All Health Care* for the child Medicaid population was statistically significantly lower than the 2022 NCQA child Medicaid national average and 2022 top-box score. However, **Upper Peninsula Health Plan** has reported several performance improvement initiatives that continue to be in progress. HSAG recommends that **Upper Peninsula Health Plan** continue to implement performance improvement interventions and evaluate their effectiveness.

5. Medicaid Health Plan Comparative Information

In addition to performing a comprehensive assessment of each MHP's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each MHP to assess the CHCP. Specifically, HSAG identifies any patterns and commonalities that exist across the nine MHPs and the CHCP, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which MDHHS could leverage or modify Michigan's CQS to promote improvement.

Medicaid Health Plan External Quality Review Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the MHPs.

Validation of Performance Improvement Projects

For the SFY 2023 validation, the MHPs submitted Remeasurement 1 data for the state-mandated PIP topic addressing disparities in care. Table 5-1 displays each PIP and whether a disparity exists, and provides a comparison of the validation rating and outcome scores by MHP.

Table 5-1—Comparison of PIP Validation by MHP

MHP	Disparity	PIP Topic	Overall PIP Validation Rating	Design, Implementation, and Outcomes Scores		
				Met	*Partially Met*	*Not Met*
AET	Yes	*Addressing Disparities in Timeliness of Prenatal Care*	*Met*	95%	5%	0%
BCC	Yes	*Reducing Racial Disparities Within Timeliness of Prenatal Care*	*Met*	95%	0%	5%
HAP	No[1]	*Improving the Timeliness of Prenatal Care*	*Met*	96%	0%	4%
MCL	Yes	*Addressing Disparities in Timeliness of Prenatal Care*	*Met*	95%	0%	5%
MER	Yes	*Addressing Disparities for Timeliness of Prenatal Care: Addressing Racial Health Disparities*	*Met*	95%	0%	5%

MHP	Disparity	PIP Topic	Overall PIP Validation Rating	Design, Implementation, and Outcomes Scores		
				Met	*Partially Met*	*Not Met*
MOL	Yes	*Addressing Disparities for Timeliness of Prenatal Care*	*Met*	90%	5%	5%
PRI	Yes	*Improving Timeliness of Prenatal Care for African-American Women*	*Met*	97%	0%	3%
UNI	No[1]	*Addressing Disparities in Timeliness of Prenatal Care*	*Met*	95%	0%	5%
UPP	Yes	*Reducing Racial Disparities in Adult Ambulatory and Preventive Access to Care in Members ages 20-44*	*Met*	95%	0%	5%

[1]The MHP did not identify a disparity; therefore, the PIP was focused on its lowest-performing population.

Table 5-2 provides a comparison of the MHPs' PIPs by target population(s) and results, including a summary of each MHP's progress on meeting the goals of the PIP.

Table 5-2—Comparison of PIP Target Population and Results by MHP

MHP	Target Population(s)	Results		Progress on Meeting Goals
		Baseline	R1	
AET	Disparate: Rural population	47.5%	58.6% ⇔	✓ Existing disparity eliminated ✓ Programmatically significant improvement achieved ✓ Rate for disparate population increased × Rate for comparison population declined
	Comparison: Urban population	63.9%	61.7% ⇔	
BCC	Disparate: Black women	66.98%	67.05% ⇔	✓ Clinically significant improvement achieved ✓ Programmatically significant improvement achieved ✓ Rate for disparate population increased × Existing disparity not eliminated × Rate for comparison population declined
	Comparison: White women	76.61%	73.66% ⇔	
HAP	Black/African-American women[1]	72.4%	75.1% ⇔	✓ Rate for population increased × Significant improvement not achieved
MCL	Disparate: Black members	60.8%	62.1% ⇔	✓ Clinically significant improvement achieved ✓ Rate for disparate population increased

MHP	Target Population(s)	Results		Progress on Meeting Goals
		Baseline	R1	
	Comparison: White members	71.7%	71.9% ⇔	✓ Rate for comparison population increased slightly × Existing disparity not eliminated
MER	Disparate: Black women (in Region 6)	61.9%	53.1% ⇔	✓ Programmatically significant improvement achieved × Existing disparity not eliminated × Rate for disparate population declined × Rate for comparison population declined
	Comparison: White women (in Region 6)	70.1%	62.8% ↓	
MOL	Disparate: Black women	66.2%	68.4% ⇔	✓ Existing disparity eliminated ✓ Rate for disparate population increased × Rate for comparison population declined slightly
	Comparison: White women	71.1%	71.0% ⇔	
PRI	Disparate: African-American women	69.4%	65.8% ⇔	✓ Clinically significant improvement achieved × Existing disparity not eliminated × Rate for disparate population declined × Rate for comparison population declined slightly
	Comparison: Caucasian women	86.1%	85.4% ⇔	
UNI	African-American/Black members[1]	61.5%	59.2% ⇔	× Significant improvement not achieved × Rate for population declined
UPP	Disparate: Black members	64.7%	65.8% ⇔	✓ Programmatically significant improvement achieved ✓ Rate for disparate population increased × Existing disparity not eliminated × Rate for comparison population declined
	Comparison: White members	77.4%	75.6% ↓	

R1 = Remeasurement 1
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
[1]The MHP did not identify a racial/ethnicity disparity within its population; therefore, the PIP only has one target population.

Performance Measure Validation

Table 5-3 displays the HEDIS MY 2022 performance levels. Table 5-4 displays the HEDIS MY 2021 and HEDIS MY 2022 Michigan Medicaid weighted averages, comparison of performance between MY 2021 and MY 2022, and the performance level for MY 2022 for MDHHS-selected performance measures for the annual assessment. Additional performance measures and performance measure results are included in Appendix B. Statewide weighted averages were calculated and compared from HEDIS MY 2021 to HEDIS MY 2022, and comparisons were based on a Chi-square test of statistical significance with a p value of <0.01 considered statistically significant due to large denominators. Of

note, 2021 to 2022 comparison values are based on comparisons of the exact HEDIS MY 2021 and HEDIS MY 2022 statewide weighted averages rather than on rounded values.

For most measures in Table 5-4, the performance levels compare the HEDIS MY 2022 statewide weighted average to the NCQA Quality Compass national Medicaid HMO percentiles for HEDIS MY 2021 (referred to as "percentiles"), as displayed in Table 5-3.[5-1]

Table 5-3—HEDIS MY 2022 Performance Levels

Performance Levels	Percentile
★★★★★	90th percentile and above
★★★★	75th to 89th percentile
★★★	50th to 74th percentile
★★	25th to 49th percentile
★	Below 25th percentile

Table 5-4—Overall Statewide Averages for HEDIS MY 2021 and HEDIS MY 2022 Performance Measures

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care				
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.84%	60.06%	**+1.22⁺**	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.99%	60.86%	-0.13	★★
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	58.13%	59.20%	**+1.07⁺**	★★★
Ages 12 to 17 Years	49.93%	50.38%	**+0.45⁺**	★★
Ages 18 to 21 Years	29.01%	28.31%	**-0.70⁺⁺**	★★★
Total	50.49%	50.89%	**+0.40⁺**	★★★
Women—Adult Care				
Chlamydia Screening in Women				
Ages 16 to 20 Years	58.09%	59.35%	**+1.26⁺**	★★★
Ages 21 to 24 Years	64.15%	66.34%	**+2.19⁺**	★★★
Total	61.00%	62.76%	**+1.76⁺**	★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	58.01%	59.16%	**+1.15⁺**	★★★

[5-1] MY 2022 performance levels were based on comparisons to national Medicaid HMO Quality Compass HEDIS MY 2021 benchmarks.

Measure	HEDIS MY 2021	HEDIS MY 2022	MY 2021–2022 Comparison[1]	MY 2022 Performance Level[2]
Breast Cancer Screening				
Breast Cancer Screening	52.30%	53.68%	**+1.38**+	★★★
Living With Illness				
Hemoglobin A1c Control for Patients With Diabetes				
*Poor HbA1c Control (>9.0%)**	43.04%	39.01%	**-4.03**+	★★★
HbA1c Control (<8.0%)	48.26%	53.53%	**+5.27**+	★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	54.56%	54.81%	+0.25	★★★
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	59.61%	66.93%	**+7.32**+	★★★
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	30.62%	35.09%	**+4.47**+	★★★
Ages 65 to 74 Years	29.92%	36.52%	**+6.60**+	★★★
Ages 75 to 85 Years	30.27%	34.44%	+4.17	★★
Total	30.57%	35.16%	**+4.59**+	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	56.14%	62.07%	**+5.93**+	★★★

[1]Weighted averages were calculated and compared from HEDIS MY 2021 to HEDIS MY 2022, and comparisons were based on a Chi-square test of statistical significance with a *p* value of <0.01 due to large denominators. Rates shaded green with one cross (+) indicate statistically significant improvement from the previous year. Rates shaded red with two crosses (++) indicate statistically significantly decline in performance from the previous year. Of note, MY 2021–2022 Comparison values are based on comparisons of the exact HEDIS MY 2021 and HEDIS MY 2022 statewide weighted averages, not rounded values.

[2] Performance Levels for MY 2022 were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks.

* For this indicator, a lower rate indicates better performance.

Performance Levels for HEDIS MY 2022 represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 5-5 presents, by measure, the number of MHPs that performed at each performance level. The counts include only measures with a valid, reportable rate that could be compared to percentiles. Therefore, not all row totals will equal nine MHPs.

Table 5-5—Count of MHPs by Performance Level

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Child & Adolescent Care					
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	1	3	1	2	2
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	4	4	1	0	0
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	1	1	7	0	0
Ages 12 to 17 Years	2	4	3	0	0
Ages 18 to 21 Years	0	4	5	0	0
Total	1	3	5	0	0
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	1	0	3	5	0
Ages 21 to 24 Years	1	0	5	2	1
Total	1	0	3	5	0
Cervical Cancer Screening					
Cervical Cancer Screening	1	2	6	0	0
Breast Cancer Screening					
Breast Cancer Screening	0	1	7	1	0
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*Poor HbA1c Control (>9.0%)**	1	1	3	2	2
HbA1c Control (<8.0%)	1	0	3	2	3
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	0	0	6	3	0
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	1	1	0	5	2
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	1	2	5	1	0
Ages 65 to 74 Years	1	3	4	1	0

Measure	Number of Stars				
	★	★★	★★★	★★★★	★★★★★
Ages 75 to 85 Years	2	2	3	1	1
Total	1	2	5	1	0
Controlling High Blood Pressure					
Controlling High Blood Pressure	1	2	3	1	2
Total	**22**	**35**	**78**	**32**	**13**

* For this indicator, a lower rate indicates better performance.
Performance Levels for MY 2022 represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table 5-6 provides an MHP-to-MHP comparison with the statewide average in the four selected HEDIS measure domains. Green represents best MHP performance in comparison to the statewide average. Red represents worst MHP performance in comparison to the statewide average.

Table 5-6—MHP-to-MHP Comparison and Statewide Average

HEDIS Measure	Statewide Average	AET	BCC	HAP	MCL	MER	MOL	PRI	UNI	UPP
Child & Adolescent Care										
Well-Child Visits in the First 30 Months of Life										
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	60.06%	46.55%	67.72%	52.44%	65.02%	55.37%	60.34%	53.15%	63.74%	70.23%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.86%	52.30%	63.64%	47.35%	62.08%	59.29%	62.30%	59.86%	60.54%	68.09%
Child and Adolescent Well-Care Visits										
Ages 3 to 11 Years	59.20%	52.67%	59.79%	47.26%	58.39%	59.96%	59.81%	61.72%	57.05%	56.40%
Ages 12 to 17 Years	50.38%	43.72%	48.29%	36.91%	47.20%	51.05%	52.58%	51.71%	50.53%	50.27%
Ages 18 to 21 Years	28.31%	24.46%	29.30%	22.12%	23.31%	27.32%	30.90%	29.23%	30.71%	23.73%
Total	50.89%	44.17%	50.85%	38.98%	48.46%	51.78%	52.05%	52.87%	50.04%	48.65%

HEDIS Measure	Statewide Average	AET	BCC	HAP	MCL	MER	MOL	PRI	UNI	UPP
Women—Adult Care										
Chlamydia Screening in Women										
Ages 16 to 20 Years	59.35%	65.99%	60.81%	64.90%	52.46%	61.07%	62.27%	57.75%	59.47%	43.20%
Ages 21 to 24 Years	66.34%	67.43%	65.78%	66.17%	62.53%	70.85%	67.89%	65.55%	63.50%	48.69%
Total	62.76%	66.78%	63.55%	65.78%	57.54%	65.64%	64.89%	61.47%	61.33%	45.75%
Cervical Cancer Screening										
Cervical Cancer Screening	59.16%	47.69%	60.30%	56.45%	55.06%	60.34%	59.37%	61.31%	58.88%	61.80%
Breast Cancer Screening										
Breast Cancer Screening	53.68%	47.70%	53.29%	54.95%	54.65%	53.52%	53.48%	53.81%	53.45%	59.84%
Living With Illness										
Hemoglobin A1c Control for Patients With Diabetes										
*HbA1c Poor Control (>9.0%)**	39.01%	37.96%	34.06%	35.77%	58.64%	38.93%	41.85%	30.41%	33.09%	30.17%
HbA1c Control (<8.0%)	53.53%	52.55%	59.61%	56.20%	34.79%	54.99%	50.61%	57.66%	59.12%	61.07%
Eye Exam for Patients With Diabetes										
Eye Exam for Patients With Diabetes	54.81%	54.26%	54.01%	58.88%	52.55%	55.23%	53.53%	54.48%	56.93%	60.83%
Blood Pressure Control for Patients With Diabetes										
Blood Pressure Control for Patients With Diabetes	66.93%	59.12%	70.07%	61.07%	47.69%	67.88%	67.64%	68.61%	75.18%	82.00%
Kidney Health Evaluation for Patients With Diabetes										
Ages 18 to 64 Years	35.09%	23.13%	34.76%	37.86%	30.99%	39.26%	28.90%	35.93%	40.62%	36.10%
Ages 65 to 74 Years	36.52%	28.85%	40.39%	44.93%	20.63%	34.38%	31.82%	39.29%	51.15%	36.67%
Ages 75 to 85 Years	34.44%	25.00%	37.93%	43.10%	NA	29.30%	26.87%	41.40%	57.46%	29.58%
Total	35.16%	24.11%	34.85%	39.52%	30.94%	38.78%	29.07%	36.20%	41.30%	35.99%
Controlling High Blood Pressure										
Controlling High Blood Pressure	62.07%	57.91%	58.81%	62.53%	46.47%	62.77%	63.26%	73.24%	65.45%	79.08%

* For this indicator, a lower rate indicates better performance.

NA indicates that the MHP followed the specifications, but the denominator was too small to report a valid rate.

Compliance Review

MDHHS calculated the CHCP overall performance in each of the six performance areas. Table 5-7 compares the CHCP average compliance score in each of the six performance areas (i.e., standards) with the compliance score achieved by each MHP. The percentages of requirements met for each of the six standards reviewed during the SFY 2023 compliance review are provided.

Table 5-7—Compliance Monitoring Comparative Results

Standard		AET	BCC	HAP	MCL	MER	MOL	PRI	UNI	UPP	CHCP[1]
1	Administrative	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
2	Providers	96%	96%	96%	96%	96%	96%	96%	96%	87%	**94.7%**
3	Members	100%	100%	97%	93%	97%	100%	97%	100%	97%	**97.7%**
4	Quality	95%	100%	100%	100%	100%	100%	100%	100%	100%	**99.5%**
5	MIS/Financial	95%	95%	95%	95%	93%	98%	98%	100%	98%	**96.1%**
6	OIG/Program Integrity	97%	86%	94%	94%	100%	97%	77%	71%	94%	**90.2%**
Overall Score		**97%**	**95%**	**96%**	**95%**	**97%**	**98%**	**93%**	**93%**	**95%**	**95.5%**

Indicates the highest-performing MHP(s) in the standard.

Indicates the lowest-performing MHP(s) in the standard.

[1] MDHHS calculated statewide performance scores to the tenths place decimal; however, MHP performance scores were calculated using whole number percentages.

Network Adequacy Validation

During May and June 2023, HSAG completed an NVS among PCPs, pediatric providers, and OB/GYN providers contracted with one or more MHP to ensure members have appropriate access to provider information. The NVS included a PDV in which HSAG compared key indicators published in each online provider directory with the data in the MHPs' provider files. HSAG then validated the accuracy of the online provider directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories.

Table 5-8 summarizes findings by MHP regarding the number of sampled providers and provider locations (i.e., "cases") that HSAG's reviewers were able to locate in the MHPs' online directories.

Table 5-8—Summary of Sampled Providers Located in Online Directories

MHP	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory	
		Count	%	Count	%
AET	351	286	81.5%	65	18.5%
BCC	262	252	96.2%	10	3.8%

MHP	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory	
		Count	%	Count	%
HAP	334	327	97.9%	7	2.1%
MCL	307	281	91.5%	26	8.5%
MER	321	311	96.9%	10	3.1%
MOL	346	326	94.2%	20	5.8%
PRI	319	308	96.6%	11	3.4%
UNI	290	273	94.1%	17	5.9%
UPP	109	102	93.6%	7	6.4%
MHP Total	**2,639**	**2,466**	**93.4%**	**173**	**6.6%**

Table 5-9 and Table 5-10 display, by MHP and study indicator, the percentage of sampled provider locations identified in the online directories with exact matches between the MHPs' provider data files and the online provider directory. Cases with unmatched results may include spelling discrepancies, incomplete information, or information not listed in the directory (e.g., the MHP's provider data included a data value for a study indicator, but the online provider directory did not include a data value for the study indicator).[5-2]

Table 5-9—Study Indicator Matches

	AET		BCC		HAP		MCL		MER	
Indicator	Count	%	Count	%	Count	%	Count	%	Count	%
Provider's Name	285	99.7%	252	100%	325	99.4%	281	100%	311	100%
Provider Street Address	228	79.7%	215	85.3%	313	95.7%	278	98.9%	302	97.1%
Provider Suite Number	257	89.9%	238	94.4%	318	97.2%	281	100%	307	98.7%
Provider City	264	92.3%	228	90.5%	318	97.2%	278	98.9%	304	97.7%
Provider State	286	100%	251	99.6%	327	100%	281	100%	311	100%
Provider ZIP Code	256	89.5%	224	88.9%	318	97.2%	280	99.6%	304	97.7%
Provider Telephone Number	248	86.7%	211	83.7%	312	95.4%	279	99.3%	251	80.7%
Provider Type/Specialty	273	95.5%	244	96.8%	327	100%	280	99.6%	301	96.8%
Provider Accepting New Patients	275	96.2%	251	99.6%	326	99.7%	279	99.3%	310	99.7%
Provider Gender	285	99.7%	251	99.6%	326	99.7%	280	99.6%	308	99.0%
Provider Primary Language*	286	100%	251	99.6%	159	48.6%	276	98.2%	173	55.6%

[5-5] The denominator for each study indicator includes the number of cases in which the provider was found in the directory (i.e., as shown in Table 5-8).

	AET		BCC		HAP		MCL		MER	
Indicator	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Non-English Language Speaking Provider (including American Sign Language)*	267	93.4%	222	88.1%	318	97.2%	194	69.0%	288	92.6%

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

Table 5-10—Study Indicator Matches (continued)

	MOL		PRI		UNI		UPP		MHP Total	
Indicator	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Provider's Name	326	100%	308	100%	273	100%	102	100%	**2,463**	**99.9%**
Provider Street Address	316	96.9%	299	97.1%	254	93.0%	101	99.0%	**2,306**	**93.5%**
Provider Suite Number	319	97.9%	303	98.4%	271	99.3%	102	100%	**2,396**	**97.2%**
Provider City	326	100%	302	98.1%	263	96.3%	101	99.0%	**2,384**	**96.7%**
Provider State	326	100%	306	99.4%	272	99.6%	102	100%	**2,462**	**99.8%**
Provider ZIP Code	324	99.4%	301	97.7%	261	95.6%	101	99.0%	**2,369**	**96.1%**
Provider Telephone Number	310	95.1%	219	71.1%	249	91.2%	99	97.1%	**2,178**	**88.3%**
Provider Type/Specialty	323	99.1%	306	99.4%	268	98.2%	100	98.0%	**2,422**	**98.2%**
Provider Accepting New Patients	303	92.9%	303	98.4%	273	100%	101	99.0%	**2,421**	**98.2%**
Provider Gender	313	96.0%	308	100%	272	99.6%	102	100%	**2,445**	**99.1%**
Provider Primary Language*	325	99.7%	298	96.8%	273	100%	102	100%	**2,143**	**86.9%**
Non-English Language Speaking Provider (including American Sign Language)*	251	77.0%	258	83.8%	270	98.9%	75	73.5%	**2,143**	**86.9%**

The denominator for each study indicator includes the number of cases in which the provider location was found in the directory.
* PDV review evaluated whether the indicator was present in the directory, but specific values were not validated.

HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. HSAG attempted to contact 2,098 sampled provider locations (i.e., "cases"), with an overall response rate of 67.1 percent (n=1,408). Table 5-11 summarizes the MHPs' secret shopper survey results.

Table 5-11—Summary of Secret Shopper Survey Results

MHP	Total Survey Cases	Response Rate		Confirmed Provider		Confirmed Location		Offering Specialty		Accepting Insurance	
		Cases Reached	Response Rate (%)	Confirmed Provider	Rate (%)	Confirmed Location	Rate (%)	Offering Specialty	Rate (%)	Accepting Insurance	Rate (%)
AET	227	165	72.7%	90	54.5%	77	46.7%	74	44.8%	66	40.0%
BCC	202	111	55.0%	59	53.2%	55	49.5%	51	45.9%	45	40.5%
HAP	309	216	69.9%	164	75.9%	153	70.8%	134	62.0%	98	45.4%
MCL	274	162	59.1%	103	63.6%	98	60.5%	53	32.7%	44	27.2%
MER	244	175	71.7%	145	82.9%	141	80.6%	136	77.7%	108	61.7%
MOL	286	227	79.4%	167	73.6%	162	71.4%	135	59.5%	116	51.1%
PRI	217	121	55.8%	95	78.5%	92	76.0%	74	61.2%	55	45.5%
UNI	242	142	58.7%	78	54.9%	73	51.4%	42	29.6%	35	24.6%
UPP	97	89	91.8%	84	94.4%	82	92.1%	80	89.9%	69	77.5%
MHP Total	**2,098**	**1,408**	**67.1%**	**985**	**70.0%**	**933**	**66.3%**	**779**	**55.3%**	**636**	**45.2%**

Table 5-12 displays the number of cases in which the survey respondent offered appointments to new patients for routine services, as well as summary wait time statistics. Note that potential appointment dates may have been offered with any practitioner at the sampled location.

Table 5-12—Appointment Availability Results

MHP	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)	Cases Offered an Appointment		Appointment Wait Time (Days)		Percentage of Cases Meeting Appointment Standard[2]
			Number[1]	Rate (%)	Average	Median	
AET	63	38.2%	63	38.1%	13	5	87.5%
BCC	38	34.2%	38	63.2%	21	12	75.0%
HAP	92	42.6%	92	60.9%	8	6	94.6%
MCL	36	22.2%	36	91.7%	19	13	84.8%
MER	94	53.7%	94	64.9%	20	10	67.2%
MOL	110	48.5%	110	63.6%	24	15	75.7%
PRI	49	40.5%	49	57.1%	27	19	53.6%
UNI	26	18.3%	26	50.0%	16	12	84.6%

MHP	Cases Contacted and Accepting New Patients	Rate of Cases Accepting New Patients (%)	Cases Offered an Appointment		Appointment Wait Time (Days)		Percentage of Cases Meeting Appointment Standard[2]
			Number[1]	Rate (%)	Average	Median	
UPP	68	76.4%	68	66.2%	24	13	66.7%
MHP Total	**576**	**40.9%**	**576**	**61.5%**	**19**	**10**	**76.3%**

[1] The denominator includes cases responding to the survey and indicating that the office is affiliated with the requested provider and that at least one practitioner at the location accepts the requested insurance and new patients.
[2] Rates were calculated using the total number of respondents to the survey who offered an appointment as the denominator, and respondents to the survey who offered an appointment date that is compliant with the 30-business-day standard for routine appointments and seven-business-day standard for prenatal care appointments as the numerator.

Encounter Data Validation

Table 5-13 presents the EDV results for all MHPs. Results for the administrative profile are stratified by category of service. For both analyses, cells with a "✓" indicate no or minor concerns noted, cells with a "–" indicate moderate concerns noted, and cells with an "x" indicate major concerns noted. For MHP-specific results, refer to Section 3.

Table 5-13—EDV MHP Comparison

Analysis		AET	BCC	HAP	MCL	MER	MOL	PRI	UNI	UPP
IS Review										
Encounter Data Sources and Systems		✓	✓	✓	✓	✓	✓	✓	✓	✓
Payment Structures		✓	✓	✓	✓	✓	✓	✓	✓	✓
Encounter Data Quality Monitoring		–	✓	–	–	–	–	✓	✓	✓
Administrative Profile										
Encounter Data Completeness	Professional	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Institutional	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encounter Data Timeliness	Professional	✓	✓	✓	✓	–	–	✓	✓	✓
	Institutional	✓	✓	✓	✓	–	✓	✓	✓	✓
	Dental	✓	✓	✓	✓	✓	x	✓	x	✓
	Pharmacy	✓	–	–	✓	✓	✓	–	–	✓

Analysis		AET	BCC	HAP	MCL	MER	MOL	PRI	UNI	UPP
Field-Level Completeness and Accuracy	Professional	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Institutional	✓	✓	✓	✓	–	✓	✓	✓	✓
	Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Pharmacy	✓	–	–	✓	✓	✓	–	–	✓
Encounter Referential Integrity	Professional	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Institutional	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Pharmacy	–	–	–	–	–	–	–	–	–
Encounter Data Logic	Professional	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Institutional	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓	✓

✓	No or minor concerns noted.
–	Moderate concerns noted.
×	Major concerns noted.

Consumer Assessment of Healthcare Providers and Systems Analysis

Comparative analyses identified whether one MHP performed statistically significantly higher or lower on each measure compared to the program average for a specific population, as well as the overall member experience ratings when 2023 scores were compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data and 2022 scores were compared to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data.[5-3,5-4,5-5,5-6,5-7] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in Table 5-14.

Table 5-14—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

5-3 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

5-4 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

5-5 The source for the national data contained in this publication is Quality Compass® 2022 and is used with the permission of NCQA. Quality Compass 2022 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

5-6 Since certain survey questions in the CAHPS 5.1 Child Medicaid Health Plan Survey were modified for inclusion in the CSHCS Survey, the results are not comparable to the NCQA benchmark data; therefore, NCQA comparison results were not presented in the 2022 and 2023 Michigan CSHCS CAHPS Reports. Only the scores and statistically significant results are presented in the Michigan CSHCS comparison tables.

5-7 Since scores were updated to two decimal places in the 2023 Michigan Adult and Child Medicaid CAHPS Reports and the 2023 Michigan HMP CAHPS Report, the star ratings for the 2022 scores could be different than what was presented in the 2022 Michigan Adult and Child Medicaid CAHPS Reports and the 2022 Michigan HMP CAHPS Report.

Table 5-15 through Table 5-16 provide a summary of the statistically significant findings (noted with arrows) from the MHP comparisons, as well as the overall member experience ratings (noted with stars) from the NCQA comparisons of the adult and child Medicaid populations. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2023 Medicaid Managed Care Program average.

Table 5-15—Statewide Comparisons: Adult Medicaid Global Ratings

Program/ Plan Name	*Rating of Health Plan*		*Rating of All Health Care*		*Rating of Personal Doctor*		*Rating of Specialist Seen Most Often*	
	2022	2023	2022	2023	2022	2023	2022	2023
Medicaid Managed Care Program	★★★ **63.74%**	★★★ **63.43%**	★★ **56.22%**	★★★ **58.01%**	★★ **66.52%**	★★ **64.71%**	★★ **66.50%**	★ **64.05%**
AET	★★★ 65.31%	★ 57.89%	★ 51.61%	★★ 54.19%	★★ 67.74%	★★ 68.00%	★★ 66.25%+	★ 64.66%
BCC	★★★★ 69.14%	★★★ 63.23%	★★★ 59.20%	★★★ 58.74%	★★ 65.57%	★ 62.14%	★★★★ 74.07%	★ 63.36%
HAP	★★★ 64.22%	★★★ 63.89%	★★★ 59.29%	★★★ 57.14%	★★★ 72.68%	★★★ 71.03%	★★ 67.78%+	★ 63.10%+
MCL	★★ 59.57%	★★★ 63.35%	★★ 58.06%	★★★ 57.14%	★★★ 69.50%	★★ 65.41%	★ 62.22%+	★ 56.04%+
MER	★★ 61.67%	★★★ 63.76%	★ 49.59%	★★ 56.58%	★ 63.16%	★★ 65.22%	★ 61.64%+	★ 64.65%+
MOL	★★ 61.98%	★★★ 65.67%	★★ 55.75%	★★★★ 62.50%	★ 64.71%	★★ 65.67%	★★ 67.00%	★★★ 68.00%
PRI	★★★★ 66.67%	★★ 61.72%	★★★ 61.84%	★ 52.00%	★★ 65.52%	★★ 64.80%	★★★★ 75.47%	★ 60.20%+
UNI	★★★ 63.30%	★★★ 62.64%	★★★ 60.87%	★★★★ 62.18%	★★★ 72.30%	★ 62.33%	★ 64.00%+	★★★ 69.41%+
UPP	★★★★★ 71.12%	★★★ 64.44%	★★ 56.13%	★ 52.81%	★★★ 71.87%	★★ 67.48%	★ 62.84%	★ 64.61%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 Medicaid Managed Care Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 Medicaid Managed Care Program average.

No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 Medicaid Managed Care Program average.

Table 5-16—Statewide Comparisons: Adult Medicaid Composite Measures

Program/ Plan Name	*Getting Needed Care*		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*	
	2022	2023	2022	2023	2022	2023	2022	2023
Medicaid Managed Care Program	★★ **82.85%**	★★★ **83.46%**	★★ **82.02%**	★★★ **83.21%**	★★ **91.38%**	★★ **91.85%**	★★★★ **91.45%**	★★ **88.56%**
AET	★★ 83.36%	★★★ 83.11%	★★★ 84.43%+	★★ 77.26% ↓	★★★ 92.74%	★★ 91.04%	★★★ 89.86%+	★★★ 89.65%
BCC	★★ 83.50%	★★★ 84.50%	★★ 80.31%	★★★ 82.90%	★★ 92.11%	★★ 92.10%	★★★★★ 92.68%+	★★★★ 91.65%
HAP	★ 80.93%	★★ 80.54%	★★★★+ 85.21%	★★ 78.70%+	★★★★★ 95.35%	★★★ 93.32%	★★★★ 91.64%	★★★ 90.26%+
MCL	★★★ 85.28%	★★★★★ 87.78%	★★★★ 85.43%	★★★★★ 87.87%	★★★★ 94.15%	★★ 92.11%	★ 87.13%+	★★ 88.34%+
MER	★ 79.21%+	★★ 81.81%	★ 78.82%+	★★★ 82.68%	★ 89.04%	★★ 91.44%	★★★ 90.60%+	★★★ 90.55%+
MOL	★★★★ 87.01%	★★ 82.10%	★★★ 83.84%	★★ 79.94%	★ 88.63%	★ 90.47%	★★★★★ 94.88%+	★ 83.68%
PRI	★★★ 84.78%	★★★ 83.70%	★★★★ 85.81%	★★★★★ 90.11%+ ↑	★★★ 92.93%	★★★ 93.49%	★★★ 90.40%+	★★★★★ 92.35%+
UNI	★ 79.79%+	★★★ 83.65%	★★ 79.54%+	★★ 80.29%+	★★★ 93.10%	★★ 91.76%	★★★★ 91.71%+	★ 82.84%+
UPP	★★★ 84.35%	★★★ 83.19%	★★★★ 87.09%	★★★★ 85.88%	★★★★★ 95.42%	★★★★★ 95.44%	★★★★★ 94.81%	★★★★★ 92.77%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 Medicaid Managed Care Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 Medicaid Managed Care Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 Medicaid Managed Care Program average.

Table 5-17—Statewide Comparisons: Adult Medicaid Individual Item and Medical Assistance With Smoking and Tobacco Use Cessation Items

Program/ Plan Name	*Coordination of Care*		*Advising Smokers and Tobacco Users to Quit**		*Discussing Cessation Medications**		*Discussing Cessation Strategies**	
	2022	2023	2022	2023	2022	2023	2022	2023
Medicaid Managed Care Program	★★ **83.51%**	★★★ **85.97%**	★★★ **75.48%**	★★★★ **76.80%**	★★★ **54.80%**	★★★★ **55.74%**	★★ **47.28%**	★★★ **49.16%**
AET	★ 79.71%+	★★ 84.43%	★★ 72.37%	★★ 70.86%	★★★★ 57.89%	★★★ 54.34%	★★★ 50.34%	★★★★ 51.20%
BCC	★★★★ 90.80%+	★★★ 85.22%	★★ 74.48%	★★★ 75.48%	★★ 51.56%	★★★ 54.49%	★★ 43.98%	★★★ 47.40%
HAP	★★ 84.93%+	★★★ 86.67%+	★ 70.73%	★ 65.69%	★★ 51.61%	★★ 46.08%	★★ 44.35%	★ 38.83%
MCL	★★ 85.06%+	★★ 83.95%+	★ 70.72%	★★ 72.05%	★★ 50.00%	★★ 50.31%	★★ 43.89%	★★★ 46.54%
MER	★ 72.73%+	★★★★ 87.37%+	★★ 74.10%	★★★★ 78.13%	★★★ 54.94%	★★★★ 55.20%	★★ 45.96%	★★★★ 50.39%
MOL	★★ 83.84%+	★★★★ 87.18%	★★★ 79.05%	★★★★★ 82.45%	★★★★★ 61.84%	★★★★★ 62.11%	★★★★ 54.81%	★★★★★ 55.38%
PRI	★★★★★ 92.13%+	★★★★★ 91.78%+	★★★ 76.92%	★★★ 74.80%	★★ 49.42%	★★★ 51.56%	★★ 44.71%	★★ 40.77%
UNI	★★★ 88.06%+	★ 79.31%+	★★★ 79.19%	★★★★ 78.57%	★★★ 56.76%	★★★★★ 61.26%	★★★ 47.62%	★★★★ 51.85%
UPP	★★ 83.72%	★★★★ 87.65%	★★★ 76.40%	★★★ 73.44%	★★★★ 58.87%	★★★ 53.18%	★★★★ 52.69%	★★★ 48.10%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 Medicaid Managed Care Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 Medicaid Managed Care Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 Medicaid Managed Care Program average.

Table 5-18—Statewide Comparisons: Child Medicaid Global Ratings

Program/ Plan Name	Rating of Health Plan		Rating of All Health Care		Rating of Personal Doctor		Rating of Specialist Seen Most Often	
	2022	2023	2022	2023	2022	2023	2022	2023
Medicaid Managed Care Program	★ **67.42%**	★★ **70.50%**	★ **68.79%**	★ **66.74%**	★ **73.33%**	★ **74.00%**	★ **68.41%**	★★★ **72.25%**
AET	★ 64.80%	★ 66.67%	★ 63.38%+	★ 67.54%	★ 72.45%+	★★ 74.72%	★★★★★ 80.00%+	★ 65.96%+
BCC	★★ 70.98%	★★★ 72.76%	★★★ 74.80%	★★ 68.79%	★ 72.92%	★ 72.97%	★ 70.83%+	★★ 71.67%+
HAP	★★ 71.30%	★★ 69.14%	★ 64.20%+	★★ 69.70%+	★ 71.72%+	★ 72.46%	★★★★ 76.67%+	★★★★★ 84.85%+
MCL	★ 62.74%	★★ 71.43%	★ 70.73%	★ 59.44%	★ 71.66%	★★ 74.78%	★ 62.50%+	★★★ 74.70%+
MER	★★ 68.80%	★★ 70.29%	★ 68.67%	★★ 68.64%	★ 74.02%	★ 73.58%	★ 69.57%+	★★★ 75.76%+
MOL	★ 63.27%	★★ 71.05%	★ 65.87%	★ 65.07%	★ 68.50%	★★ 74.65%	★ 57.45%+	★★ 70.91%+
PRI	★★ 70.74%	★★ 69.83%	★★ 72.95%	★ 67.07%	★★ 77.99%	★★ 75.85%	★★ 72.50%+	★★★ 72.22%+
UNI	★ 68.30%	★★ 68.65%	★ 63.87%	★★ 69.57%	★★ 75.98%	★ 72.90%	★★★★ 76.60%+	★ 67.31%+
UPP	★ 67.51%	★★ 70.43%	★ 70.20%	★ 60.93%	★★ 76.68%	★ 73.09%	★★★ 75.00%+	★ 63.77%+

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 Medicaid Managed Care Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 Medicaid Managed Care Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 Medicaid Managed Care Program average.

Table 5-19—Statewide Comparisons: Child Medicaid Composite[5-8]

Program/ Plan Name	*Getting Needed Care*		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*		*Transportation*	
	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023
Medicaid Managed Care Program	★★ **84.33%**	★★★ **86.13%**	★★ **87.55%**	★★★ **89.01%**	★★★ **94.94%**	★★★ **94.92%**	★★★ **88.04%**	★★★★★ **92.12%**	**48.96%+**	**65.96%+**
AET	★★★ 88.31%+	★★ 82.12%+	★★★ 88.73%+	★★ 85.03%+	★ 91.79%+	★ 92.23%	★ 85.19%+	★★★★ 90.04%+	62.50%+	55.56%+
BCC	★★ 82.82%+	★★ 83.22%	★★★ 88.30%+	★★★ 89.54%	★★★ 95.33%	★★★★★ 96.83%↑	★ 84.96%+	★★★ 88.04%+	NA	NA
HAP	★★ 82.68%+	★ 79.24%+	★★ 86.94%+	★★★ 87.50%+	★★ 93.32%+	★★ 93.96%	★★★★ 90.54%+	★★ 86.79%+	NA	NA
MCL	★★★ 86.06%+	★★★★ 88.13%	★★★★ 90.69%+	★★★ 89.75%	★★★ 95.01%	★★ 94.20%	★★★★★ 94.32%+	★★★★ 90.38%+	NA	NA
MER	★★ 85.09%	★★★ 87.24%	★★★ 88.70%+	★★★ 89.03%	★★★ 95.38%	★★★ 95.61%	★ 86.49%+	★★★★★ 96.14%+↑	NA	NA
MOL	★★ 83.72%+	★★★ 85.43%	★★ 87.26%+	★★★ 89.65%	★★★ 94.62%	★★★ 95.04%	★★★★★ 93.31%+	★★★★★ 91.67%+	73.08%+	56.67%+
PRI	★★★ 86.60%+	★★★★★ 93.49%↑	★★★ 89.63%+	★★★★ 90.60%	★★★ 95.29%	★★★★ 96.36%	★★ 86.84%+	★★★★★ 94.10%+	NA	NA
UNI	★ 80.88%+	★ 80.31%	★ 79.82%+	★★ 85.81%	★★ 94.04%	★ 90.94%↓	★ 82.77%+	★★★ 88.10%+	NA	NA
UPP	★★★ 87.37%	★★★★★ 89.89%↑	★★★★★ 94.19%	★★★★★ 92.67%	★★★★ 97.08%	★★★★★ 98.48%↑	★★★★ 90.61%+	★★★★★ 97.30%+↑	NA	79.41%+

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA Indicates that results for this measure are not displayed because too few members responded to the questions.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 Medicaid Managed Care Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 Medicaid Managed Care Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 Medicaid Managed Care Program average.

[5-8] The *Transportation* composite measure survey questions are not included in the standard CAHPS 5.1H Child Medicaid Health Plan Survey. These questions are NCQA-approved supplemental items that were added to the survey. A 2022 and 2023 NCQA benchmark is not available for this measure.

Table 5-20—Statewide Comparisons: Child Medicaid Individual Item Measures

	Coordination of Care	
Program/Plan Name	**2023**	**2022**
Medicaid Managed Care Program	★★ **83.57%**	★★★ **86.33%**
AET	★★★ 88.46%+	★★ 83.02%+
BCC	★ 75.47%+	★★ 82.76%+
HAP	★★ 87.10%+	★★ 82.35%+
MCL	★ 76.36%+	★★ 83.72%+
MER	★★ 85.94%+	★★★★★ 94.19%+↑
MOL	★ 81.54%+	★ 80.60%+
PRI	★★ 87.76%+	★★★★★ 91.43%+
UNI	★★★★ 89.58%+	★ 79.69%+
UPP	★★ 84.69%+	★★★★★ 91.00%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 Medicaid Managed Care Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 Medicaid Managed Care Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 Medicaid Managed Care Program average.

Table 5-21 through Table 5-23 provide a summary of the statistically significant findings (noted with arrows) of the CSHCS population analysis. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2023 CSHCS Managed Care Program average. Triangles (▲ or ▼) indicate 2023 CSHCS Managed Care Program average scores were statistically significantly higher or lower than the 2022 CSHCS Managed Care Program average scores.

Table 5-21—Statewide Comparisons: CSHCS Global Ratings

Program/ Plan Name	Rating of Health Plan		Rating of Health Care		Rating of Specialist Seen Most Often		Rating of CMDS Clinic	
	2022	2023	2022	2023	2022	2023	2022	2023
CSHCS Managed Care Program	**67.33%**	**67.37%**	**70.23%**	**67.94%**	**73.50%**	**73.95%**	**75.99%**	**69.33%**
AET	58.33%+	81.25%+	69.23%+	88.89%+	NA	85.71%+	NA	NA
BCC	69.44%	65.49%	69.57%	68.30%	73.65%	70.48%	63.64%+	55.56%+
HAP	61.54%+	76.92%+	50.00%+	76.92%+	NA	NA	NA	NA
MCL	69.71%	68.64%	73.47%	72.02%	75.78%	78.65%	63.16%+	79.49%+
MER	65.63%	63.98%	71.65%	68.69%	73.59%	75.54%	77.78%+	56.41%+
MOL	64.18%	66.67%	69.17%	66.43%	68.82%	75.13%	80.95%+	84.38%+
PRI	73.08%	67.62%	72.22%	65.87%	78.06%	70.06%	88.00%+	70.59%+
UNI	65.11%	71.07%	66.32%	66.67%	70.49%	73.85%	72.73%+	68.09%+
UPP	67.37%+	73.33%	73.68%+	69.16%	83.58%+	77.42%+	88.24%+	85.71%+

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 CSHCS Managed Care Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 CSHCS Managed Care Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 CSHCS Managed Care Program average.
▲ Indicates the 2023 CSHCS Managed Care Program average is statistically significantly higher than the 2022 CSHCS Managed Care Program average.
▼ Indicates the 2023 CSHCS Managed Care Program average is statistically significantly lower than the 2022 CSHCS Managed Care Program average.
No triangles (▲ or ▼) indicate the 2023 CSHCS Managed Care Program average was not statistically significantly higher or lower than the 2022 CSHCS Managed Care Program average.
NA Indicates that results for this measure are not displayed because too few members responded to the questions.

Table 5-22—Statewide Comparisons: CSHCS Composite Measures

Program/ Plan Name	Customer Service		How Well Doctors Communicate		Access to Specialized Services		Transportation	
	2022	2023	2022	2023	2022	2023	2022	2023
CSHCS Managed Care Program	**86.65%**	**85.84%**	**94.99%**	**93.64%**	**70.88%**	**69.98%**	**73.98%**	**64.05%**
AET	NA	NA	95.45%+	96.15%+	NA	NA	NA	NA
BCC	82.09%+	82.35%+	94.33%	92.52%	67.72%+	67.06%+	55.67%+	NA
HAP	NA	NA	95.83%+	100.00%+ ↑	NA	NA	NA	NA
MCL	87.88%+	95.95%+ ↑	95.50%	95.44%	76.53%+	72.03%+	78.63%+	82.05%+
MER	85.84%+	83.12%+	95.17%	93.08%	70.54%+	64.39%+	74.26%+	54.66%+ ↓
MOL	86.10%+	86.68%+	93.41%	94.99%	73.36%+	67.36%+	82.35%+	64.84%+
PRI	98.04%+	85.96%+	96.30%	93.89%	70.15%+	72.60%+	87.12%+	70.54%+
UNI	84.00%+	83.90%+	95.25%	90.92% ↓	69.99%+	76.47%+	61.09%+	79.29%+
UPP	91.18%+	92.50%+	98.01%+	98.77%+ ↑	70.11%+	75.47%+	97.22%+	92.37%+ ↑

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 CSHCS Managed Care Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 CSHCS Managed Care Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 CSHCS Managed Care Program average.
▲ Indicates the 2023 CSHCS Managed Care Program average is statistically significantly higher than the 2022 CSHCS Managed Care Program average.
▼ Indicates the 2023 CSHCS Managed Care Program average is statistically significantly lower than the 2022 CSHCS Managed Care Program average.
No triangles (▲ or ▼) indicate the 2023 CSHCS Managed Care Program average was not statistically significantly higher or lower than the 2022 CSHCS Managed Care Program average.
NA Indicates that results for this measure are not displayed because too few members responded to the questions.

Table 5-23—Statewide Comparisons: CSHCS Individual Item Measures

Program/ Plan Name	Access to Prescription Medicines		CMDS Clinic		Local Health Department Services		Not Felt Treated Unfairly: Race and Ethnicity		Not Felt Treated Unfairly: Health Insurance Type	
	2022	2023	2022	2023	2022	2023	2022	2023	2022	2023
CSHCS Managed Care Program	**90.71%**	**88.95%**	**84.40%**	**81.83%**	**77.01%**	**78.04%**	**96.64%**	**96.93%**	**94.84%**	**93.42%**
AET	NA	100.00%+	NA	NA	NA	NA	81.82%+	92.31%+	81.82%+	100.00%+
BCC	87.50%	85.80%	76.47%+	67.86%+	76.19%+	79.69%+	95.34%	97.55%	94.33%	95.73%
HAP	90.91%+	NA	NA	NA	NA	NA	100.00%+	100.00%+↑	100.00%+	100.00%+
MCL	94.02%	89.39%	79.49%+	90.00%+	77.22%+	78.82%+	96.74%	99.49% ↑	92.43%	95.41%
MER	88.67%	86.92%	77.14%+	80.95%+	78.57%	77.68%	99.22%	96.98%	93.31%	92.78%
MOL	92.04%	89.62%	87.18%+	80.56%+	76.60%+	74.24%+	95.79%	96.65%	95.79%	90.87%
PRI	93.41%	91.71%	96.00%+	87.50%+	78.85%+	76.67%+	97.18%	97.47%	96.02%	94.44%
UNI	90.19%	88.26%	91.30%+	85.71%+	74.47%+	80.36%+	95.65%	93.81%	96.74%	91.75%
UPP	90.41%+	96.10%+	94.12%+	93.33%+	81.82%+	89.74%+	96.05%+	100.00%+↑	97.37%+	95.06%+

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 CSHCS Managed Care Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 CSHCS Managed Care Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 CSHCS Managed Care Program average.
▲ Indicates the 2023 CSHCS Managed Care Program average is statistically significantly higher than the 2022 CSHCS Managed Care Program average.
▼ Indicates the 2023 CSHCS Managed Care Program average is statistically significantly lower than the 2022 CSHCS Managed Care Program average.
No triangles (▲ or ▼) indicate the 2023 CSHCS Managed Care Program average was not statistically significantly higher or lower than the 2022 CSHCS Managed Care Program average.
NA Indicates that results for this measure are not displayed because too few members responded to the questions.

Table 5-24 through Table 5-26 provide a summary of the statistically significant findings (noted with arrows) of the HMP population analysis, as well as the overall member experience ratings (noted with stars) from the NCQA comparisons. Arrows (↑ or ↓) indicate 2023 scores were statistically significantly higher or lower than the 2023 HMP Program average.

Table 5-24—Statewide Comparisons: HMP Global Ratings

Program/ Plan Name	*Rating of Health Plan*		*Rating of All Health Care*		*Rating of Personal Doctor*		*Rating of Specialist Seen Most Often*	
	2022	2023	2022	2023	2022	2023	2022	2023
HMP Program	★★★ **62.57%**	★★ **60.87%**	★★ **56.43%**	★★★ **57.96%**	★★ **68.70%**	★★ **66.19%**	★★ **65.55%**	★★ **65.82%**
AET	★ 56.44%	★★ 59.68%	★ 50.94%+	★★★ 57.38%+	★ 61.90%+	★ 62.65%+	★ 58.97%+	★ 62.22%+
BCC	★★ 61.58%	★★★★ 66.37%	★★★ 58.49%	★★★ 58.04%	★★ 68.38%	★★★ 69.66%	★★ 67.61%+	★★★ 71.43%+
HAP	★ 56.43%	★★★ 66.15%	★ 54.55%+	★★★★ 60.56%+	★★ 68.09%+	★★★ 70.83%+	★ 63.04%+	★★★★★ 75.93%+
MCL	★★ 62.04%	★★ 59.19%	★ 50.00%	★★ 56.72%	★ 63.64%	★ 60.92%	★ 58.02%+	★ 62.20%+
MER	★★★ 64.44%	★ 54.22% ↓	★ 53.40%	★★ 55.07%	★★★ 70.42%	★★ 64.33%	★ 58.46%+	★ 62.92%+
MOL	★★★★ 67.02%	★★★ 65.05%	★★★ 58.33%	★★★★★ 65.31%+	★★★ 71.23%	★★ 67.38%	★★ 68.75%+	★★★ 68.06%+
PRI	★★ 59.92%	★★★ 63.81%	★★ 57.14%	★★ 56.45%	★★ 67.36%	★★ 67.88%	★★★ 69.79%+	★ 61.73%+
UNI	★★ 58.91%	★ 56.94%	★★★★ 65.45%	★★★ 56.78%	★★★ 71.25%	★★ 65.45%	★★★★★ 76.92%+	★★ 66.67%+
UPP	★★★★ 67.17%	★★★★ 66.78%	★ 51.56%	★★ 55.49%	★★ 65.63%	★★★★ 72.92%	★★★ 72.41%	★ 63.55%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 HMP Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 HMP Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 HMP Program average.

Table 5-25—Statewide Comparisons: HMP Composite Measures

Program/ Plan Name	*Getting Needed Care*		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*	
	2022	2023	2022	2023	2022	2023	2022	2023
HMP Program	★★ **81.57%**	★★★ **84.53%**	★★ **80.53%**	★★★ **82.13%**	★★★ **92.63%**	★★★ **93.34%**	★ **86.93%**	★★ **87.45%**
AET	★★+ 83.09%	★★★★★ 87.97%+	★★★+ 84.19%	★ 76.33%+	★★ 92.22%+	★★ 92.80%+	★ 80.56%+	★★★ 90.22%+
BCC	★★ 83.59%+	★★★★ 86.70%+	★★ 82.22%+	★★★★ 85.60%+	★★★★★ 96.18%+	★★★★★ 96.48% ↑	★ 86.27%+	★★ 88.67%+
HAP	★★ 82.77%+	★★ 79.96%+	★ 78.16%+	★★★★ 86.67%+	★★★★ 94.03%+	★★★★★ 98.96% +↑	★ 85.53%+	★ 81.40%+
MCL	★★★ 84.92%	★★★★★ 89.52%	★ 76.44%+	★★★ 81.13%+	★★ 91.86%	★ 89.68%	★★★ 89.29%+	★★ 86.98%+
MER	★ 75.71%+	★★ 80.86%	★ 79.01%+	★★ 78.49%	★ 89.81%	★★ 91.53%	★★★ 90.00%+	★★ 86.92%+
MOL	★ 76.90%+	★★★★ 86.59%+	★★ 80.51%+	★★★ 84.09%+	★★ 91.18%	★★★★★ 95.50%	★ 81.73%+	★★ 88.00%+
PRI	★★ 83.72%	★★★★ 85.41%	★★ 80.08%	★★★ 82.64%	★★ 91.58%	★★★ 93.62%	★ 83.81%+	★★★ 90.48%+
UNI	★★★★★+ 89.29%	★★ 79.18%	★★★ 83.98%+	★★★ 82.00%+	★★★★★ 95.58%	★★ 91.64%	★★★ 89.49%+	★ 84.91%+
UPP	★★★ 84.87%	★★★★ 87.17%	★★★★ 86.04%	★★★ 83.24%	★★★★★ 95.35%	★★★★ 94.59%	★★★ 90.00%+	★ 84.75%+

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 HMP Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 HMP Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 HMP Program average.

Table 5-26—Statewide Comparisons: HMP Individual Item and Medical Assistance With Smoking and Tobacco Use Cessation Items

Program/ Plan Name	*Coordination of Care*		*Advising Smokers and Tobacco Users to Quit**		*Discussing Cessation Medications**		*Discussing Cessation Strategies**	
	2022	2023	2022	2023	2022	2023	2022	2023
HMP Program	★ **81.51%**	★★★ **85.53%**	★★★ **77.27%**	★★★ **75.90%**	★★★ **57.06%**	★★★★ **54.97%**	★★★ **47.42%**	★★★ **48.89%**
AET	★ 79.17%+	★★★★ 89.29%+	★★★★ 81.48%+	★★★★ 77.22%+	★★★★ 58.02%+	★★★ 51.90%+	★★ 43.75%+	★★★★ 50.00%+
BCC	★★★★ 88.89%+	★★★★★ 93.33%+	★★★★★ 82.14%+	★★★★ 78.51%	★★★★★ 63.39%	★★★★★ 63.64%	★★★★ 55.36%	★★★★★ 61.16% ↑
HAP	★★★★ 90.48%+	★★ 83.33%+	★ 63.64%+	★ 64.94%+	★ 45.45%+	★★ 48.05%+	★ 36.84%+	★ 39.47%+
MCL	★ 76.92%+	★ 81.16%+	★★ 72.96%	★★★ 73.08%	★★ 50.31%	★★ 48.46%	★ 42.50%	★★ 41.98%
MER	★ 75.00%+	★★ 81.58%+	★★★ 76.43%	★★ 72.93%	★★★ 56.96%	★★★ 52.24%	★★ 45.86%	★★ 43.28%
MOL	★ 82.76%+	★★★★ 87.88%+	★★★★★ 82.12%	★★★★★ 87.20% ↑	★★★★ 58.78%	★★★★ 60.00%	★★★ 48.32%	★★★★★ 53.97%
PRI	★★★ 86.67%+	★★★★★ 89.61%+	★★★ 75.74%	★★ 72.31%	★★★ 56.80%	★★★ 53.44%	★★★ 47.93%	★★★ 45.80%
UNI	★ 80.36%+	★ 79.03%+	★★ 74.22%	★★ 71.79%	★★★ 56.00%	★★ 51.28%	★★ 45.31%	★★★ 46.15%
UPP	★★★ 86.05%+	★★★ 84.62%+	★ 69.71%	★★★ 73.06%	★★ 50.41%	★★★ 52.70%	★★ 45.00%	★★★ 48.18%

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
* These rates follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2023 score is statistically significantly higher than the 2023 HMP Program average.
↓ Indicates the 2023 score is statistically significantly lower than the 2023 HMP Program average.
No arrows (↑ or ↓) indicate the 2023 score was not statistically significantly higher or lower than the 2023 HMP Program average.

Quality Rating

HSAG analyzed MY 2022 HEDIS results, including MY 2022 CAHPS data from the nine MHPs, for presentation in the 2023 Michigan Consumer Guide. The 2023 Michigan Consumer Guide analysis helps to support MDHHS' public reporting of health plan performance information. The 2023 Michigan Consumer Guide used a three-level rating scale to provide potential and enrolled Medicaid members with an easy-to-read "picture" of quality performance across MHPs and presented data in a manner that emphasizes meaningful differences between MHPs. The 2023 Michigan Consumer Guide used apples to display results for each MHP, which correlated to the performance ratings defined in Table 5-27. Table 5-28 shows the 2023 Michigan Consumer Guide, which demonstrates MHP comparative performance in MDHHS-established categories.

Table 5-27—Apple Ratings for the 2023 Michigan Consumer Guide

Rating	Plan Performance Compared to Statewide Average	
🍎🍎🍎🍎🍎	Above Average	The health plan's performance was above average compared to Michigan Medicaid health plans
🍎🍎🍎	Average	The health plan's performance was average compared to Michigan Medicaid health plans
🍎🍎	Below Average	The health plan's performance was below average compared to Michigan Medicaid health plans

Table 5-28—2023 Michigan Consumer Guide

Plan	Overall Rating*	Doctors' Communication and Service	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna Better Health of Michigan^^	🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎	🍎🍎	🍎🍎
Blue Cross Complete of Michigan	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎	🍎🍎	🍎🍎🍎🍎
HAP CareSource**	🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎	🍎🍎🍎	🍎🍎🍎
McLaren Health Plan	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎	🍎🍎	🍎🍎
Meridian Health Plan of Michigan^	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎
Molina Healthcare of Michigan	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎	🍎🍎🍎	🍎🍎🍎
Priority Health Choice, Inc.^	🍎🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎	🍎🍎🍎🍎	🍎🍎🍎🍎
UnitedHealthcare Community Plan^^	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎	🍎🍎🍎🍎	🍎🍎🍎
Upper Peninsula Health Plan	🍎🍎🍎🍎	🍎🍎🍎	🍎🍎🍎🍎	🍎🍎🍎🍎	🍎🍎🍎🍎	🍎🍎🍎🍎

**This rating includes all categories. This rating also includes how the member feels about their plan and healthcare.*
***formerly HAP Empowered*
^indicates the plan received Health Equity Accreditation from the National Committee for Quality Assurance (NCQA) as of October 2023.
^^ indicates the plan received Health Equity Accreditation Plus from NCQA as of October 2023. Further details may be found on the NCQA website located here: https://reportcards.ncqa.org/methodology.

6. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the MHPs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the CHCP to identify programwide conclusions. HSAG presents these programwide conclusions and corresponding recommendations to MDHHS to drive progress toward achieving the goals of the 2020–2023 MDHHS CQS and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid members.

Table 6-1—Programwide Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal #1—Ensure high quality and high levels of access to care	**Conclusions:** While MDHHS required the MHPs to report on an extensive list of HEDIS performance measures (refer to Appendix B for results and analysis of all measures), it identified a subset of performance measures of focus for this annual EQR within the Child & Adolescent Care, Women—Adult Care, and Living With Illness domains. All domains demonstrated strengths of the CHCP. • Within the Child & Adolescent Care domain, four rates for the *Well-Child Visits in the First 30 Months of Life* and *Child and Adolescent Well-Care Visits* performance measures ranked between the 50th and 74th Medicaid Quality Compass percentile, with four rates also demonstrating a statistically significant improvement from the prior year. • Four rates under the Women—Adult Care domain ranked between the 50th and 74th Medicaid Quality Compass percentile and one ranked between the 75th and 89th percentile. Further, all five rates within this domain for *Chlamydia Screening in Women*, *Cervical Cancer Screening*, and *Breast Cancer Screening* demonstrated a statistically significant improvement from the prior year. • Within the Living With Illness domain, the CHCP demonstrated strengths in the management of diabetes and hypertension. All but one rate for the *Hemoglobin A1c Control for Patients With Diabetes*, *Eye Exam for Patients With Diabetes*, *Blood Pressure Control for Patients With Diabetes*, *Kidney Health Evaluation for Patients With Diabetes*, and *Controlling High Blood Pressure* performance measures ranked between the 50th and 74th Medicaid Quality Compass percentile, with seven rates demonstrating a statistically significant improvement from the prior year. Further, while the rate for *Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years* only ranked	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	between the 25th and 49th percentile, the rate also improved compared to the prior year's rate. Overall, the CHCP has improved the percentage of children and adolescents who received well-care visits, women who received screenings for cancer and STIs, and members who received appropriate management of diabetes and hypertension. The CHCP should continue to build on this momentum and continue efforts to improve member engagement in care; and therefore, improve performance levels based on comparisons to national percentiles. However, the results of the NAV activity indicated that some of the CHCP's members may experience challenges contacting or scheduling appointments with PCPs, pediatric providers, and OB/GYN providers due to invalid provider telephone or address, provider type/specialty, and/or insurance information. Further, of providers responding to the secret shopper survey and accepting the insurance and new patients, only 61.5 percent of providers offered the caller an appointment and only 76.3 percent of those appointments met MDHHS' established appointment time frame standards (i.e., 30 business days for routine care appointments and seven business days for prenatal care appointments). Long wait times for appointments may lead to patient dissatisfaction. Further, for the CAHPS measure, *Rating of Personal Doctor*, the CHCP only received a *Fair* or *Poor* rating for the adult Medicaid, child Medicaid, and HMP populations. While many members were receiving appropriate care and services as demonstrated by the HEDIS results, dissatisfaction with providers may discourage members from making appointments for preventive care or the management of chronic conditions. **Recommendations:** MDHHS has updated the 2023–2026 CQS to include measurable quality measures that support achievement of the goals and objectives of Goal #1. The establishment of measurable quality measures will allow MDHHS to complete an evaluation of the effectiveness of its CQS using quantitative data. As such, HSAG recommends that MDHHS include all validated performance measures included as a Quality Measure under each goal and objective within the CQS as focus measures for each annual EQR. Additionally, to keep the MHPs accountable to the goals and objectives of the CQS, MDHHS could contractually require the	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	MHPs to include a specific section dedicated to the CQS within each MHP's annual QAPI program evaluation. MDHHS should require this section to include an analysis of the impact, positive or negative, the MHP had on meeting the goals and objectives of the CQS using the MHP's performance results for the quality measures established by MDHHS for the CHCP program. For any quality measure for which the MHP had a negative impact, the MHP should include an initiative in the QAPI program to improve performance. This recommendation applies to all goals of the CQS and is not specific to Goal #1.	
Goal #2—Strengthen person and family-centered approaches	**Conclusions:** To promote PCMHs as an integral component of the delivery system, MDHHS contractually requires the MHPs to support the transformation of primary care practices into PCMHs and to commit to increasing the percentage of members receiving services from PCMH-designated practices. Additionally, MDHHS requires members receiving CSHCS to be assigned to primary care practices that provide family-centered care (i.e., family-centered medical homes). Patient-centered and family-centered care is a model of care to ensure care for members and families is managed across a continuum of care and specialty services. MDHHS monitors various requirements that support the objectives of Goal #2 through the compliance review activity; and specifically, through the Providers, Members, and Quality standards (e.g., care coordination, addressing SDOH, navigating community resources, referrals to behavioral health and SUD providers, and access to culturally competent care). The SFY 2023 compliance review results demonstrated high performance for the CHCP as the statewide rate for the Providers, Members, and Quality standards were 94.7 percent, 97.7 percent, and 99.5 percent, respectively. However, the findings for SFY 2023 CAHPS activity demonstrated mixed results with member experiences of care for most measures across the adult Medicaid, child Medicaid, CSHCS, and HMP populations. Particularly for the child Medicaid population, there are substantial opportunities to improve member experiences related to their healthcare and personal doctor as the CHCP received a *Poor* rating for the related measures, *Rating of All Health Care* and *Rating of Personal Doctor*. MDHHS has included several CAHPS measures to the 2023–2026 CQS to allow for a more targeted evaluation of MDHHS' progress in meeting Goal #2. MDHHS has also updated the 2023–2026 CQS to include other measurable quality measures, in addition to CAHPS measures, for the CHCP to support achievement of the goals and objectives of Goal #2. The establishment of measurable quality measures will	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	allow MDHHS to complete an evaluation of the effectiveness of its CQS using quantitative data. **Recommendations:** Federal Medicaid managed care regulations require managed care entities to conduct PIPs that focus on clinical and non-clinical areas. As such, HSAG recommends that MDHHS identify a poor performing CAHPS measure (e.g., *Rating of All Health Care* and *Rating of Personal Doctor* for the child Medicaid population) and require the MHP to implement a non-clinical PIP that focuses on improving member experience for the selected measure. The identification of barriers and subsequent implemented interventions should support progress toward achieving Goal #2.	
Goal #3—Promote effective care coordination and communication of care among managed care programs, providers, and stakeholders (internal and external)	**Conclusions:** In support of Objective 3.2: *Support the integration of services and improve transitions across the continuum of care among providers and systems serving the managed care populations*, MDHHS requires each MHP to develop and execute a transition of care policy for when members transition from FFS to the MHP or from one MHP to another. The MHPs' transition of care policy is monitored by MDHHS through the compliance review activity. Each MHP's policy must be available to the public, cover out-of-network providers, ensure continuation of services, and ensure transitional supply of medications. The SFY 2023 compliance review activity confirmed that the MHPs met MDHHS' expectations as all MHPs received a *Met* score for element *3.27 Transition of Care Policy*. Element *3.2 Member Handbook* also requires the member handbook to inform members of the MHP's transition of care policy. All MHPs received a *Met* score for this element. Additionally, member satisfaction with care coordination can be evaluated through the CAHPS activity. The SFY 2023 CAHPS results indicated that more members reported that their PCP seemed informed about the care they received from other providers as demonstrated by a *Good* rating (i.e., at or between the 50th and 74th percentiles) for the *Coordination of Care* measure for the adult Medicaid and HMP populations. Further, to support collaboration between the MHPs and PIHPs, MDHHS has established Integration of Behavioral Health and Physical Health Services performance metrics as part of a Performance Bonus: *Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH)*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)*, and *Implementation of Joint Care Management Processes*. Timely	☒ Quality ☐ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	follow-up care following an inpatient or emergency room stay supports effective care coordination during transitions of care. Further, in support of Objective 3.3: *Promote the use of and adoption of health information technology and health information exchange to connect providers, payers, and programs to optimize patient outcomes* and through the *Implementation of Joint Care Management Processes* metric, MDHHS requires the MHPs to develop joint care plans with the PIHPs who provide behavioral health services, through MDHHS' care management tool within its IS platform, CC360. MDHHS contractually requires MHPs to utilize CC360 to document a jointly created care plan and to track contacts, issues, and services regarding members shared by both entities (i.e., MHP and PIHP) who have significant behavioral health issues and complex physical comorbidities. While the results of the Performance Bonus are not available to HSAG through this annual EQR, the *Effectiveness Evaluation Appendix C—Results of 2020-2023 CQS Goals & Objectives Program Evaluation Assessments* as reported through the 2023–2026 CQS, indicated that the CHCP met two of the three objectives under Goal #3. The evaluation further suggested that while shared MHP and PIHP metrics are examples of improving transitions of care among providers and systems, the separation of the behavioral health system and physical health system under the CHCP makes integration of care difficult. **Recommendations:** To ensure the CHCP does not manage and coordinate care through siloed programs, HSAG recommends that MDHHS continue to strategize innovative ways to further integrate the physical health system and the behavioral health system. Additionally, MDHHS has updated the 2023–2026 CQS to include *Implementation of Joint Care Management Processes* as a quality measure to support Goal #3 with the 2026 statewide performance target being *All applicable plan combinations to have at least one shared care plan in CC360*. This implies that only one member per plan combination over a three-year period (i.e., 2023–2026) would need to have a joint care plan created to meet the statewide goal. While having a joint care plan may have a positive impact on health outcomes for a member (i.e., one member per plan combination), it does not appear that this target would substantially drive quality improvement for the CHCP. HSAG recommends that MDHHS re-evaluate the appropriateness of this performance target or further clarify the intent or rationale behind setting this as MDHHS' 2026 goal.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	MDHHS has also included *Follow-Up After Hospitalization for Mental Illness Within 30 Days (FUH)* as a quality measure for Goal #3 in the 2023–2026 CQS. While a 2026 statewide performance target has been established, a baseline rate has yet to be determined. HSAG recommends that MDHHS proceed with establishing the baseline rate for this measure and re-evaluate the appropriateness of the 2026 goal based on the baseline rate. Further, for the CSHCS population, MDHHS has established 2026 statewide performance targets for the *Coordination of Care* and *Global Rating of Health Care* quality measures (i.e., CAHPS measures). However, the 2026 targets do not drive quality improvement as they are a lower rate than the baseline rate. HSAG recommends that MDHHS re-evaluate the appropriateness of setting a three-year performance minimum performance target lower than the CHCP's baseline rate. As CMS has placed strong emphasis on interoperability through the CMS-9115-F, and most recently, the CMS-0057-F enhancing the API requirements, HSAG also recommends that MDHHS consider potential quality measures related to the APIs to include in future revisions of the 2023–2026 CQS to promote Goal #3. For example, as CMS-9115-F is requiring reporting of Patient Access API usage, MDHHS could consider this as a future quality measure to support Goal #3. Lastly, the API requirements are included under 42 CFR §438.242 Health information systems, which requires Medicaid managed care plans to implement the APIs and must be reviewed as part of the compliance review activity. However, in review of MDHHS' compliance review methodology, the API requirements are not currently included in the compliance review activity. HSAG recommends that MDHHS evaluate each MHP's compliance with the API requirements and incorporate the API requirements in future compliance review activities.	
Goal #4—Reduce racial and ethnic disparities in healthcare and health outcomes	**Conclusions:** MDHHS contractually requires the MHPs to participate in the Medicaid Health Equity Project. MDHHS publishes an annual health equity report, most recently in August 2023, which reports select performance measure data stratified by four racial populations (Asian American/Native Hawaiian/Other Pacific Islander, African American, American Indian/Alaska Native, and White) and one ethnicity (Hispanic). The August 2023	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	report,[6-1] reflecting the MY 2022 rate, identified that the African-American Medicaid managed care population had significantly lower rates than the White population in nine of the 11 measures, with the largest disparity occurring for the *Childhood Immunization Status—Combination 3* measure. MDHHS uses this data to initiate health equity projects. The MHPs are also contractually required to develop a health equity program with an annual workplan to narrow disparities. Health equity measures have been increasing in weight and priority in determining MHP performance bonus and incentives. The *Childhood Immunization Status—Combination 3* measure was included in the SFY 2023 MHP Performance Bonus program. Additionally, for SFY 2023, the MHPs were responsible for continuing their PIP topics to address healthcare disparities. Through the MHPs' analyses of their data, seven of the nine MHPs identified an existing disparity.[6-2] As demonstrated through the SFY 2023 PIP validation, all nine MHPs designed a methodologically sound PIP and implemented interventions based on the barriers identified through each MHP's data analysis and quality improvement processes. Of the seven MHPs with an existing disparity, while only two were successful at eliminating the disparity during the current reporting period, five MHPs demonstrated a rate increase for their disparate population. Further, processes concerning health equity are monitored by MDHHS through the compliance review activity and specifically through elements *3.26 Diversity, Equity, and Inclusion (DEI) Assessment and Training* and *4.10 Addressing Health Disparities – Population Health Mgmt (PHM)*. The SFY 2023 compliance review findings confirmed that all MHPs met MDHHS' expectations for these two elements. A discussion of health disparities was also incorporated into the SFY 2023 focus studies. For the CSHCS focus study, MDHHS provided the MHPs with updates regarding the Medicaid Health Equity Project; and for the Quality focus study, MDHHS required the MHPs to report on initiatives being implemented to leverage the postpartum care coverage expansion to	

[6-1] Michigan Department of Health and Human Services, Behavioral and Physical Health and Aging Services Administration. Medicaid Health Equity Project Year 11 Report on MY 2020 Data All Medicaid Health Plans, August 2023. Available at: https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/MY2020-Medicaid-Health-Equity-Project-Year-11-Report-All-Plans.pdf?rev=f50322a580a74b0ca8e77ab65918dc13&hash=40A029FC7867E98A212517FA1262FD21. Accessed on: Jan 19, 2024.

[6-2] Six of the seven MHPs identified a racial/ethnic disparity, and one MHP identified a disparity by geographical region.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	address racial and ethnic disparities in postpartum screenings and care engagement. Lastly, MDHHS has demonstrated its commitment to reduce racial and ethnic disparities in healthcare and has updated the 2023–2026 CQS to include multiple quantitative quality measures for the CHCP to support achievement of the goals and objectives of Goal #4. **Recommendations:** Through the PIP activity, while several MHPs identified a barrier and/or an intervention for the target/disparate population, it was not always clear if all barriers and interventions listed applied to a MHP's entire population or the target/disparate population. HSAG recommends that MDHHS consider requiring the MHPs to identify whether each barrier and intervention applies to the MHP's entire population or the target/disparate population specifically. HSAG further recommends that MDHHS require that each MHP identify a certain number of barriers and interventions that must specifically address the target/disparate population.	
Goal #5—Improve quality outcomes and disparity reduction through value-based initiatives and payment reform	**Conclusions:** MDHHS has established MHP performance bonuses, through Performance Monitoring Standards, the EQI, PHM, P4P, a Performance Bonus, and an APM. The aggregated findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact these value-based initiatives and payment reform had on improving quality outcomes. However, the *Effectiveness Evaluation Appendix C—Results of 2020–2023 CQS Goals & Objectives Program Evaluation Assessments* as reported through the 2023–2026 CQS, confirmed that the CHCP met Objective 5.1: *Promote the use of value-based payment models to improve quality of care.* Under Goal #5, MDHHS established performance bonus withholds and the APM strategy as part of the performance bonus withhold with target benchmarks established for the MHPs. Additionally, MDHHS has updated the 2023–2026 CQS to include measurable quality measures for the CHCP to support achievement of the goals and objectives of Goal #5. **Recommendations:** MDHHS updated its CQS for the time span of 2023–2026 and included two performance metrics with baseline performance and performance targets for 2026 for the CHCP: *Average percentage of plan payments to providers who are in APM arrangements ("Big Numerator")* and *Average percentage of plan*	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	payments to providers that are tied to quality ("Small Numerator"). However, the 2026 target for *Average percentage of plan payments to providers that are tied to quality ("Small Numerator")* is lower than the statewide baseline rate. It is unclear why MDHHS would set a 2026 goal (i.e., CQS Objective) lower than the baseline rate as this CQS Objective would not drive improvement. The quality measure does not appear to be an inverse measure (i.e., lower rate indicates better performance) as the measure is tied to quality of care. HSAG recommends that MDHHS re-evaluate its 2026 performance target for this quality measure and update as appropriate or include the rationale for establishing a target lower than the baseline rate.	

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting External Quality Review Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCOs, PIHPs, PAHPs, and primary care case management (PCCM) entities are required to have a QAPI program, which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must involve:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve quality improvement.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The EQR technical report must include information on the validation of PIPs required by the State and underway during the preceding 12 months.

The primary objective of PIP validation is to determine the MHP's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the PIP includes two key components of the quality improvement process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MHP designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a MHP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MHP improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that MDHHS and key stakeholders can have confidence that the MHP executed a methodologically sound improvement project, and any reported improvement is related to and can be reasonably linked to the quality improvement strategies and activities conducted by the MHP during the PIP.

MDHHS requires that each MHP conduct one PIP subject to validation by HSAG. For this year's SFY 2023 validation, the eight of the 9 MHPs submitted Remeasurement 1 data for the state-mandated PIP topic, *Addressing Disparities in Timeliness of Prenatal Care*. The selected PIP topic is based on the HEDIS *Prenatal and Postpartum Care* measure; however, each MHP was required to use historical data to identify racial/ethnic disparities within its population related to timeliness of prenatal care.

This topic has the potential to improve the health of pregnant members through increasing early initiation of prenatal care. Women who do not receive adequate or timely prenatal care are at an increased risk of complications and poor birth outcomes. The selected study topic addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

Of note, one MHP (i.e., UPP) did not have a disparity related to timeliness of prenatal care. Therefore, MDHHS permitted this MHP to focus on reducing racial disparities in adult ambulatory and preventive access to care in members between the ages of 20 and 44 years.

Technical Methods of Data Collection and Analysis

In its PIP evaluation and validation, HSAG used CMS EQR Protocol 1. Using this protocol, HSAG, in collaboration with MDHHS, developed the PIP Submission Form. Each MHP completed this form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured all CMS EQR Protocol 1 requirements were addressed.

HSAG, with MDHHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of the PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS EQR Protocols. The HSAG PIP Team consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. The CMS EQR Protocols identify nine steps that should be validated for each PIP. For the SFY 2023 submissions, the MHPs reported Remeasurement 1 data and were validated for steps 1 through 9 in the PIP Validation Tool.

The nine steps included in the PIP Validation Tool are listed below:

1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of PIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the MHPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating of *Not Met* for the PIP. The MHP is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a *General Comment* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation rating (e.g., *Met*), HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the PIP's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported PIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Partially Met*.
- *Not Met*: All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Not Met*.

The MHPs had an opportunity to resubmit a revised PIP Submission Form and provide additional information or documentation in response to HSAG's initial validation scores of *Partially Met* or *Not Met*, regardless of whether the evaluation element was critical or noncritical. HSAG offered technical assistance to any MHP that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

HSAG conducted a final validation for any resubmitted PIPs and documented the findings and recommendations for each PIP. Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each MHP. These reports, which complied with 42 CFR §438.364, were provided to MDHHS which distributed them to the MHPs.

Description of Data Obtained and Related Time Period

For SFY 2023, the MHPs submitted Remeasurement 1 data. The type of data obtained from each MHP and the performance indicator measurement period dates are listed below.

Table A-1—Description of Data Obtained and Measurement Periods

MHP	Data Obtained	Measurement Period	Period to Which the Data Applied
AET	Administrative	Remeasurement 1	October 8, 2021–October 7, 2022
BCC	Administrative		
HAP	Hybrid		
MCL	Hybrid		
MER	Hybrid		
MOL	Administrative		
PRI	Hybrid		
UNI	Hybrid		
UPP	Administrative		

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members, HSAG validated the PIPs to ensure it used a sound methodology in its design, implementation, analysis, and reporting of the project's findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *Met*, *Partially Met*, and *Not Met*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline, prior remeasurement period results, and project goal) and qualitative results (e.g., technical design of the PIP, data analysis, and implementation of improvement strategies) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and access to care and services furnished to the MHP's Medicaid members.

Performance Measure Validation

Activity Objectives

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, PAHPs, and PCCM entities submit performance measurement data as part of their QAPI programs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(2). For the MCO, PIHP, PAHP, and PCCM entity, the EQR technical report must include information regarding the validation of performance measures (as required by the State) and/or performance measures calculated by the State during the preceding 12 months.

The primary objectives of the PMV process are to:

- Evaluate the accuracy of the performance measure data collected by the MHP.
- Determine the extent to which the specific performance measures calculated by the MHP (or on behalf of the MHP) followed the specifications established for each performance measure.

To meet the two primary objectives of the validation activity, a measure-specific review of all reported measures was performed, as well as a thorough IS evaluation, to assess each MHP's support system available to report accurate HEDIS measures. Results for a selected list of HEDIS measures, provided by MDHHS, are included in the annual assessment. However, additional performance measures and performance measure results can be referenced in Appendix B.

Technical Methods of Data Collection and Analysis

MDHHS required each MHP to collect and report a set of Medicaid HEDIS measures. Developed and maintained by NCQA, HEDIS is a set of performance measures broadly accepted in the managed care environment as an industry standard.

Each MHP underwent an NCQA HEDIS Compliance Audit conducted by an NCQA licensed organization. The NCQA HEDIS Compliance Audit followed NCQA audit methodology as set out in NCQA's MY 2022 Volume 5, *HEDIS Compliance Audit: Standards, Policies and Procedures*. The NCQA HEDIS Compliance Audit encompasses an in-depth examination of the MHPs' processes consistent with the CMS EQR Protocols. To complete the validation of the performance measure process according to CMS EQR Protocol 2, HSAG performed an independent evaluation of the audit results and findings to determine the validity of each performance measure.

Each NCQA HEDIS Compliance Audit was conducted by a certified HEDIS compliance auditor and included the following activities:

Pre-Review Activities: Each MHP was required to complete the NCQA Record of Administration, Data Management, and Processes (Roadmap), which is comparable to the Information Systems Capabilities Assessment Tool, Appendix V of the CMS EQR Protocols. Pre-on-site conference calls were held to follow up on any outstanding questions. HSAG conducted a thorough review of the Roadmap and

supporting documentation, including an evaluation of processes used for collecting, storing, validating, and reporting the performance measure data.

On-Site Review Activities: The on-site reviews, which typically lasted one to two days, included:

- An evaluation of system compliance, focusing on the processing of claims and encounters.
- An overview of data integration and control procedures, including discussion and observation.
- A review of how all data sources were combined and the method used to produce the performance measures.
- Interviews with MHP staff members involved with any aspect of performance measure reporting.
- A closing conference at which the auditor summarized preliminary findings and recommendations.

Post-On-Site Review Activities: For each performance measure calculated and reported by the MHPs, the auditor aggregated the findings from the pre-on-site and on-site activities to determine whether the reported measures were valid, based on an allowable bias. The auditor assigned each measure one of seven audit findings: (1) *Reportable* (a reportable rate was submitted for the measure), (2) *Small Denominator* (the MHP followed the specifications, but the denominator was too small [e.g., <30] to report a valid rate), (3) *No Benefit* (the MHP did not offer the health benefits required by the measure), (4) *Not Reportable* (the MHP chose not to report the measure), (5) *Not Required* (the MHP was not required to report the measure), (6) *Biased Rate* (the calculated rate was materially biased), or (7) *Un-Audited* (the MHP chose to report a measure that is not required to be audited).

HSAG performed a comprehensive review and analysis of the MHPs' Interactive Data Submission System (IDSS) results, data submission tools, and MHP-specific NCQA HEDIS Compliance Audit Reports and performance measure reports.

HSAG ensured that the following criteria were met prior to accepting any validation results:

- An NCQA-licensed organization completed the audit.
- An NCQA-certified HEDIS compliance auditor led the audit.
- The audit scope included all MDHHS-selected HEDIS measures.
- The audit scope focused on the Medicaid product line.
- Data were submitted via an auditor-locked NCQA IDSS.
- A final audit opinion, signed by the lead auditor and responsible officer within the licensed organization, was produced.

Description of Data Obtained and Related Time Period

As identified in CMS EQR Protocol 2, the following key types of data were obtained and reviewed as part of the validation of performance measures. Table A-2 shows the data sources used in the validation of performance measures and the time period to which the data applied.

Table A-2—Description of Data Sources

Data Obtained	Measurement Period
NCQA HEDIS Compliance Audit Reports were obtained for each MHP, which included a description of the audit process, the results of the IS findings, and the final audit designations for each performance measure.	Calendar Year (CY) 2022 (HEDIS MY 2022)
Performance measure reports, submitted by the MHPs using NCQA's IDSS, were analyzed and subsequently validated by HSAG.	CY 2022 (HEDIS MY 2022
Previous performance measure reports were reviewed to assess trending patterns and the reasonability of rates.	CY 2021 (HEDIS MY 2021)

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members, HSAG evaluated the results for each performance measure assigned an audit finding of *Reportable*, *Small Denominator*, *No Benefit*, *Not Reportable*, *Not Required*, *Biased Rate*, or *Un-Audited*. HSAG further analyzed the results of the MHP's HEDIS MY 2022 performance measure rates and 2022 performance levels based on comparisons to national percentiles to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MHP's Medicaid members.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MHPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the QAPI requirements described in 42 CFR §438.330. To meet this requirement, MDHHS performed annual compliance reviews of its contracted MHPs.

The objectives of conducting compliance reviews are to ensure performance and adherence to contractual provisions as well as compliance with federal Medicaid managed care regulations. The reviews also aid in identifying areas of noncompliance and assist MHPs in developing corrective actions to achieve compliance with State and federal requirements.

Technical Methods of Data Collection and Analysis

MDHHS is responsible for conducting compliance activities that assess the MHPs' conformity with State requirements and federal Medicaid managed care regulations. To meet this requirement, MDHHS identifies the requirements necessary for review during the state fiscal year and divides the requirements into a 12-month compliance monitoring schedule. The MHPs were provided with a *FY2023 MHP Contract Compliance Review Timeline* that outlined the areas of focus for each month's review and the documents required to be submitted to MDHHS to demonstrate compliance.

This technical report presents the results of the compliance reviews performed during the SFY 2023 contract year. MDHHS conducted a compliance review of six standards listed in Table A-3. Table A-3 also crosswalks MDHHS' compliance review standards to the associated federal standards and citations.

Table A-3—Compliance Review Standards Crosswalk[1]

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
1	Administrative	§438.224	§457.1233(e)
2	Providers	§438.10 §438.206 §438.207 §438.210 §438.214 §438.230	§457.1207 §457.1230(a) §457.1230(b) §457.1230(d) §457.1233(a) §457.1233(b)

MDHHS Compliance Review Standard		Federal Standard and Citation	
		Medicaid	CHIP
3	Members	§438.10 §438.100 §438.114 §438.206 §438.208 §438.210 §438.228 §438.230 Part 438, Subpart F	§457.1207 §457.1220 §457.1228 §457.1230(a) §457.1230(c) §457.1230(d) §457.1260 §457.1233(b)
4	Quality	§438.208 §438.210 §438.236 §438.330	§457.1230(c) §457.1230(d) §457.1233(c) §457.1240(b)
5	MIS/Financial	§438.56 §438.242	§457.1212 §457.1233(d)
6	OIG/Program Integrity	§438.230 Part 438, Subpart H	§457.1233(b) §457.1285

[1] HSAG and MDHHS created a crosswalk to compare MDHHS compliance review standards to federal standards, but this crosswalk should not be interpreted to mean the State's standards include all specific federal requirements under 42 CFR §438.358(b)(1)(iii).

MDHHS reviewers used a compliance review tool for each MHP to document its findings and to identify, when applicable, specific action(s) required of the MHP to address any areas of noncompliance with contractual requirements.

Attestation—For certain elements, if an MHP met requirements in the last compliance review, the MHP was allowed to attest that the previously submitted documentation was still applicable and had not changed. These attestations are allowed every other year (e.g., if an MHP attested to an item in SFY 2022, it may not attest to the item again in SFY 2023).

Deeming—As all MHPs are NCQA-accredited, MDHHS considered certain elements deemable. In order for these elements to be deemable, the MHP must have had the NCQA Medicaid module completed. If the module was completed, the MHP was only required to share the results of that survey. If the MHP did not have the NCQA Medicaid module completed, the MHP would have been required to submit documentation for MDHHS' review. The elements that MDHHS considers NCQA deemable are outlined in the MDHHS CQS. If the MHP received a *Met* score for an item within the NCQA deemable portion of the compliance review during the SFY 2022 compliance review, and the documentation had not changed, an attestation that the documentation continues to include the required content was

acceptable. If any item received a *Not Met* score in the SFY 2022 compliance review, documentation for that item must be submitted.

For each element reviewed, MDHHS assigned one of the following scores:

- *Met*—The MHP's submission met contract and compliance review requirements.
- *Not Met*—The MHP's submission did not meet contract or compliance review requirements.
- *Satisfied*—A compliance item was unable to be scored as *Met* for all portions of an item, but a narrative explanation satisfactorily justified the reason for not meeting the standard (only allowable for elements for items 5.13, 5.14, 5.15 or 5.16 within the MIS/Financial standard).

For each MHP, MDHHS calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. MDHHS calculated the total score for each standard by totaling the number of *Met* (i.e., 1 point) elements and the number of *Not Met* and *Satisfied* [A-1] (i.e., 0 points) elements, then dividing the summed score by the total number of elements for that standard. MDHHS determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements). A summary of MHP-specific and program-wide results were provided to HSAG via the *All Plans FY2023 MHP CR Results* report.

Upon receiving a *Not Met* finding, the MHPs were required to submit a CAP,[A-2] which was reviewed by MDHHS to determine acceptability. If an acceptable CAP was received by the due date, MDHHS provided documentation in the compliance review tools and the *Not Met* score remained. If a CAP was not received by the due date or if the CAP received by MDHHS did not meet requirements, the MHP was subject to financial penalties or paying liquidation damages outlined in the contact. MDHHS' CAP review process included the eight steps identified in Table A-4.

Table A-4—MDHHS CAP Review Process

Step	Entity Responsible for Completing Step	
	MDHHS	MHP
Step 1: Identify the Issue	✓	
Step 2: MHP Dispute of the CAP (optional)		✓
Step 3: MHP Corrective Action		✓

[A-1] A *Satisfied* score was considered "neutral" by MDHHS (i.e., was not counted as being a *Met* score, but does not have the same penalty as a *Not Met* score in relation to auto-assignment algorithm).

[A-2] Under limited circumstances, MDHHS did not require a CAP for a *Not Met* element. Reasons for not requiring a CAP included but were not limited to: when there is an existing or previous CAP related to the findings; an MDHHS reviewer determined the findings were not egregious due to a lack of clarity of the state-specific requirement; submission was compliant but was not submitted timely.

Step	Entity Responsible for Completing Step	
	MDHHS	MHP
Step 4: Acceptance of Corrective Action	✓	
Step 5: MHP Revised Corrective Action (if needed)		✓
Step 6: Acceptance of Revised Corrective Action (if needed)	✓	
Step 7: Effectiveness of Corrective Action Plan		✓
Step 8: Closure	✓	

Focus Studies—MDHHS also conducts annual focus studies with each MHP that consists of staff interviews and select system demonstrations, when applicable. Each year MDHHS determines the scope of the study based on current initiatives and improvement opportunities in three areas: CSHCS, Operations, and Quality. Table A-5 displays the topics included in each of the three areas.

Table A-5—Focus Study Areas and Topics

Area	Topics
CSHCS	• Equity Project with the Michigan Public Health Institute • MHP/Local Health Department Contracts • NEMT • Transition • Submission of Medicals • Office of Medical Affairs Review
Operations	• CAP Review • Network Adequacy • Adult Dental Beneficiary ID Cards • Provider Instruction for Using Medicaid ID for Billing • Grievances, Complaints, and Appeals • NEMT Record Review
Quality	• Pharmacy CAP Review • Pharmacy • Childhood Lead Poisoning Prevention Program • Immunizations • Encounters • Postpartum Care

The MHPs had pre-submission requirements for portions of the focused study in addition to the case review. MDHHS also requested that each MHP submit copies of slide decks, as applicable, and all presentation materials used during the study. Specific MDHHS staff members were responsible for taking notes during each component of the review (i.e., CSHCS, Operations, and Quality) to document the findings of the focus studies. The elements of the focus studies are not scored, but the findings were used to supplement the compliance review activity.

Description of Data Obtained and Related Time Period

To assess the MHPs' compliance with federal and State requirements, MDHHS obtained information from a wide range of materials produced by the MHPs throughout SFY 2023, including, but not limited to, the following:

- Policies and procedures
- Accreditation certificates or letters, organizational charts, governing board member appointment documentation, and board meeting minutes
- Operational plans, health plan profiles, administrative position descriptions, and management and financial reports
- Consolidated Annual Report, including financial information and member and provider incentives
- Provider contracts, network access plan, network access and provider availability documentation, and provider appeal logs
- Subcontract/delegation agreements and monitoring documentation
- CPGs and supporting documentation
- Member material timeliness documentation, including ID card mailings and new member packets
- Copies of member materials, including new member packets, member handbooks, member newsletters, member websites, and provider directories
- Maximum allowable cost (MAC) pricing reconsiderations process
- Grievance, appeal, and prior-authorization reports and notice templates
- QIPs and UM programs, quality improvement workplans and worksheets, utilization reports, quality improvement effectiveness reports, and committee meeting minutes
- Enrollment and disenrollment procedures
- PIPs
- Compliance plan and employee training documentation
- Program integrity forms and reports

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each MHP individually, HSAG used the quantitative results and percentage-of-compliance score calculated by MDHHS for each standard. HSAG determined each MHP's substantial strengths and weaknesses as follows:

- Strength—Any standard that achieved a 100 percent compliance score.
- Weakness—Any standard that scored below the statewide compliance score.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness,

HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to each MHP's Medicaid members.

Network Adequacy Validation

Activity Objectives

The primary purpose of the SFY 2023 NVS was to assess the accuracy of the managed care network information supplied to Michigan Medicaid members using the MHPs' provider data files and online provider directories, and telephone survey calls to randomly sampled provider locations. As a secondary survey objective, HSAG collected appointment availability information for routine PCP, pediatric, and OB/GYN provider visits among new patients enrolled with an MHP under the MI Medicaid program. Specific survey objectives included the following:

- Determine whether service locations accept patients enrolled with the requested MHP for the MI Medicaid program and the degree to which MHP and MI Medicaid acceptance aligns with the MHP's provider data.
- Determine whether service locations accepting MI Medicaid for the requested MHP accept new patients and the degree to which new patient acceptance aligns with the MHP's provider data.
- Determine appointment availability with the sampled provider service locations for PCP, pediatric, or OB/GYN provider visits.

Technical Methods of Data Collection and Analysis

Each MHP submitted provider data to HSAG, reflecting PCPs, pediatric providers, and OB/GYN providers contracted with the MHP at the time the data file was created who serve individuals enrolled in the MI Medicaid program. Out-of-state providers located in Indiana, Ohio, or Wisconsin within a reasonable distance of the MHPs' applicable regions were included in the study. HSAG used these data to conduct the NVS.

The NVS included a PDV in which HSAG compared key indicators published in each online provider directory with the data in the MHP's provider file. HSAG then validated the accuracy of the online provider directories by completing a secret shopper telephone survey to evaluate the accuracy of the provider information located in the directories. HSAG used an MDHHS-approved methodology and script to conduct the secret shopper telephone surveys. The secret shopper approach allows for objective data collection from healthcare providers without potential bias introduced by revealing the surveyors' identities. Using the provider data each MHP supplied to HSAG, secret shopper callers contacted sampled provider locations between April and May 2023 to inquire about appointment availability.

Several limitations and analytic considerations must be noted when reviewing NVS results:

- The provider data submitted by the MHPs in March 2023 may have changed and subsequently been updated in the MHPs' data systems and/or online provider directories prior to HSAG's PDV reviews and secret shopper survey calls in April and May 2023.

- Reviewers conducted the directory reviews using desktop computers with high-speed internet connections. Reviewers did not attempt to access or navigate the MHPs' online provider directories from mobile devices or using accessibility tools (e.g., software that reads the website content for users with limited eyesight). The current study cannot speak to whether the results are maintained across different types of devices that members may use to access provider directories.
- HSAG included cases in the telephone survey only if those cases matched on eight provider indicators in the PDV: name, address, city, state, ZIP Code, telephone number, type/specialty, and new patient acceptance. PDV cases that did not match on these indicators were not included in the secret shopper survey. It is unknown if the telephone survey results would have been better, similar, or worse among the PDV cases that did not match on the eight key indicators described.
- To maintain the secret nature of the survey and to ensure consistent data collection across cases, callers used a standardized survey script and posed as members or parents/caretakers of members who were not existing patients at the sampled provider locations. As such, survey results may not represent appointment timeliness among MHPs' members who are existing patients or who may accept scenarios outside the survey script (e.g., leaving voicemails for an office, supplying personally identifying information, or obtaining an appointment through an Internet-based scheduling portal).
- HSAG based wait time survey results on the time to the first available appointment at the sampled location. As such, survey results may underrepresent timely appointments for situations in which members are willing to travel to an alternate location.
- Survey findings were compiled from self-reported responses supplied to callers by providers' office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication (e.g., MDHHS' encounter data files, online portals, speaking to a different representative at the provider's office).
  - The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
- MHPs are responsible for ensuring that MI Medicaid members have access to a provider location within MDHHS' contract standards, rather than requiring that each individual provider or location offer appointments within specified time frames. As such, extended appointment wait times from individual provider locations should be considered in the context of the MHP's processes for assisting MI Medicaid members who require timely appointments.

Description of Data Obtained and Related Time Period

HSAG completed PDV reviews and secret shopper calls during April and May 2023. Prior to analyzing the results, HSAG reviewed the responses to ensure complete and accurate data entry.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MHP provided to members, HSAG analyzed the results of the activity to determine each MHP's substantial

strengths and weaknesses by assessing (1) the degree to which the MHPs' online provider directory information is accurate, up-to-date, and easy to locate and navigate; (2) which service locations accepted patients enrolled with the requested MHP for the MI Medicaid program and the degree to which MHP and MI Medicaid acceptance aligned with the MHPs' provider data; (3) whether service locations accepting MI Medicaid for the requested MHP accepted new patients and the degree to which new patient acceptance aligned with the MHPs' provider data; and (4) appointment availability with the sampled service locations for routine PCP, pediatric, and OB/GYN visits.

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MHPs to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2023, MDHHS contracted with HSAG to conduct an EDV study. HSAG conducted the following two core evaluation activities for all nine MHPs:

- IS review—assessment of MDHHS' and the MHPs' IS and processes. The goal of this activity is to examine the extent to which MDHHS' and the MHPs' IS infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in CMS EQR Protocol 5.
- Administrative profile—analysis of MDHHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in MDHHS' data warehouse are complete, accurate, and submitted by the MHPs in a timely manner for encounters with dates of service from October 1, 2021, through September 30, 2022. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

Information Systems Review

To ensure the collection of critical information, HSAG employed a three-stage process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

- In Stage 1: HSAG conducted a document review, examining various documents related to MDHHS' encounter data initiatives. This review included data dictionaries, process flow charts, system diagrams, and other relevant materials. The information from this review was used to create a questionnaire for MDHHS.

- In Stage 2: HSAG worked with MDHHS to develop a customized questionnaire that delved into specific data processing procedures, staff responsibilities, and data acquisition capabilities. This assessment also considered additional data systems and key topics important to MDHHS.
- In Stage 3: HSAG followed up with key staff members to clarify questionnaire responses. These follow ups allowed HSAG to document current processes and create a process map highlighting crucial factors affecting the quality of encounter data submissions.

Administrative Profile

HSAG submitted a data submission requirements document to notify MDHHS of the required data needed. The data submission requirements document was developed based on the study objectives and data elements to be evaluated in the study. It included a brief description of the study, the review period, required data elements, and information regarding the submission of the requested files.

To assist MDHHS in preparing the requested data files, HSAG took two actions. First, since it was the first time requesting data from MDHHS' warehouse, HSAG asked for test files before the complete data extraction. These smaller test files, covering a month's encounters, served two purposes. They helped detect extraction issues early and allowed HSAG to begin analysis preparations while waiting for complete data. Details were provided in the data requirements document.

Secondly, after submitting the draft data submission requirements to MDHHS, HSAG scheduled a meeting to address questions about data preparation and extraction. Depending on the complexity, an updated/final document was submitted for MDHHS review and approval.

Once the data arrived from MDHHS, HSAG conducted a preliminary file review. This ensured that the data were reasonable for evaluation, checking data extraction, field presence, and value validity. If necessary, HSAG requested data resubmission based on these results.

Once the final data had been received and processed, HSAG conducted a series of analyses for metrics listed in the sections below. In general, HSAG calculated rates for each metric by encounter type (i.e., 837 Professional [837P], 837 Institutional [837I], 837 Dental [837D], and National Council for Prescription Drug Programs [NCPDP]) and MHP. However, when the results indicated a data quality issue(s), HSAG conducted an additional investigation to determine whether the issue was for a specific category of service or subpopulation. HSAG documented all noteworthy findings in this aggregate report.

Encounter Data Completeness

HSAG evaluated encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur, or the last date of service): If the number of members remains stable and there are no major changes to members' medical/dental needs, the monthly visit/service counts should have minimal variation. A low count for any month indicates incomplete data. Of note, instead of the claim number, HSAG

evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key is based on the member ID, rendering provider NPI, and date of service.

- Monthly encounter volume (i.e., visits) per 1,000 member months by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each MHP based on the member enrollment data extracted by MDHHS.
- Paid amount per member per month by service month: This metric helps MDHHS determine whether the encounter data were complete from a payment perspective. Of note, HSAG used the header paid amount or detail paid amount to calculate this metric.
- Percentage of duplicate encounters: HSAG determined the detailed methodology (e.g., data elements and criteria) for defining duplicates after reviewing the encounter data extracted for the study and documented the method in the final report. This metric will allow MDHHS to assess the number of potential duplicate encounters in MDHHS' database.

Encounter Data Timeliness

HSAG evaluated encounter data timeliness through the following metrics:

- Percentage of encounters received by MDHHS within 360 days from the MHP payment date, in 30-day increments. This metric allows MDHHS to evaluate the extent to which the MHPs were in compliance with MDHHS' encounter data timeliness requirements.
- Claims lag triangle to illustrate the percentage of encounters received by MDHHS within two calendar months, three months, etc., from the service month. This metric allows MDHHS to evaluate how soon it may use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.

Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters were complete and accurate through the two study indicators described in Table A-6 for the key data elements listed in Table A-7. In addition, Table A-6 shows the criteria HSAG used to evaluate the validity of each data element. These criteria are based on standard reference code sets or referential integrity checks against member or provider data.

Table A-6—Study Indicators for Percent Present and Percent Valid

Study Indicator	Denominator	Numerator
Percent Present: Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table A-7 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-7.

Study Indicator	Denominator	Numerator
Percent Valid: Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-7.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table A-7. The criteria for validity are listed in Table A-7.

Table A-7—Key Data Elements for Percent Present and Percent Valid

Key Data Element	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Member ID[H]	√	√	√	√	• In member file • Enrolled in a specific MHP on the date of service • Member date of birth is on or before date of service
Header Service From Date[H]	√	√	√		• Header Service From Date ≤ Header Service To Date • Header Service From Date ≤ Paid Date
Header Service To Date[H]	√	√	√		• Header Service To Date ≥ Header Service From Date • Header Service To Date ≤ Paid Date
Detail Service From Date[D]	√	√	√		• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date[D]	√	√	√		• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Date of Service				√	• Detail Service To Date ≤ Paid Date
Billing Provider NPI[H]	√	√	√	√	• In provider data when service occurred • Meets Luhn formula requirements

Key Data Element	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Rendering Provider NPI[H]	√		√		• In provider data when service occurred • Meets Luhn formula requirements
Attending Provider NPI[H]		√			• In provider data when service occurred • Meets Luhn formula requirements
Referring Provider NPI[H]	√	√	√		• In provider data when service occurred • Meets Luhn formula requirements
Prescribing Provider NPI				√	• In provider data when service occurred • Meets Luhn formula requirements
Rendering Provider Taxonomy Code[H]	√		√		• In standard taxonomy code set • Matches the value in provider data
Attending Provider Taxonomy Code[H]		√			• In standard taxonomy code set • Matches the value in provider data
Primary Diagnosis Codes[H]	√	√	√		• In national ICD-10-Clinical Modification (CM) diagnosis code sets for the correct code year (e.g., in 2022, code set for services that occurred between October 1, 2021, and September 30, 2022)
Secondary Diagnosis Codes[H]	√	√			• In national ICD-10-CM diagnosis code sets for the correct code year

Key Data Element	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Codes[D]	√	√			• In national CPT/HCPCS code sets for the correct code year (e.g., in 2022, code set for services that occurred in 2022) AND satisfies CMS' Procedure-to-Procedure edits
Current Dental Terminology (CDT) Codes[D]			√		• In national CDT code sets for the correct code year (e.g., in 2022, code set for services that occurred in 2022)
Tooth Number			√		Primary • A–J: Maxillary • K–T: Mandibular Permanent • 1–16: Maxillary • 17–32: Mandibular
Tooth Surface1–5			√		• M—Mesial • O—Occlusal • D—Distal • I—Incisal • L—Lingual • B—Buccal • F—Facial (or Labial)

Key Data Element	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
Oral Cavity Code			√		• 00—Entire oral cavity • 01—Maxillary arch • 02—Mandibular arch • 03—Upper right sextant • 04—Upper anterior sextant • 05—Upper left sextant • 06—Lower left sextant • 07—Lower anterior sextant • 08—Lower right sextant • 09—Other area of oral cavity • 10—Upper right quadrant • 20—Upper left quadrant • 30—Lower left quadrant • 40—Lower right quadrant
Primary Surgical Procedure Codes[H]		√			• In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes[H]		√			• In national ICD-10-CM surgical procedure code sets for the correct code year
Revenue Codes[D]		√			• In national standard revenue code sets for the correct code year
Diagnosis-Related Group (DRG) Codes[H]		√			• In national standard All Patients Refined (APR)-DRG code sets for the correct code year
Type of Bill Codes[H]		√			• In national standard type of code set
National Drug Codes (NDCs)[D]	√	√		√	• In national NDC code sets
Submit Date[D]	√	√	√	√	• MHP Submission Date (i.e., the date when MHP submits encounters to MDHHS) ≥ MHP Paid Date

Key Data Element	837P Encounters	837I Encounters	837D Encounters	NCPDP Encounters	Criteria for Validity
MHP Paid Date[D]	√	√	√	√	• MHP Paid Date ≥ Detail Service To Date
Header Paid Amount[H]	√	√	√		• Header Paid Amount equal to sum of the Detail Paid Amount
Detail Paid Amount[D]	√	√	√		• Zero or positive
Paid Amount				√	• Zero or positive
Header TPL Paid Amount[H]	√	√	√		• Header TPL Paid Amount equal to sum of the Detail TPL Paid Amount
Detail TPL Paid Amount[D]	√	√	√		• Zero or positive
TPL Paid Amount				√	• Zero or positive

[H] Conduct evaluation at the header level
[D] Conduct evaluation at the detail level

Encounter Data Referential Integrity

HSAG evaluated if data sources could be joined with each other based on whether a unique identifier (e.g., unique member ID and unique provider NPI) was present in both data sources (i.e., unique member IDs that are in both the encounter and member enrollment files). If an encounter contained more than one NPI (e.g., rendering provider NPI and billing provider NPI on a professional encounter), HSAG included both unique NPIs in the analysis. Table A-8 lists the study indicators that HSAG calculated.

Table A-8—Key Indicators of Referential Integrity

Data Source	Indicator
Medical/Dental Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Medical/Dental Encounter
Pharmacy Encounters vs Member Enrollment	• Direction 1: Percentage of Members With a Pharmacy Encounter Who Were Also in the Enrollment File • Direction 2: Percentage of Members in the Enrollment File With a Pharmacy Encounter

Data Source	Indicator
Medical/Dental Encounters vs Pharmacy Encounters	• Direction 1: Percentage of Members With a Medical/Dental Encounter Who Also Have a Pharmacy Encounter • Direction 2: Percentage of Members With a Pharmacy Encounter Who Also Have a Medical/Dental Encounter
Medical/Dental Encounters vs Provider File	• Direction 1: Percentage of Providers in the Medical/Dental Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Medical/Dental Encounter File
Pharmacy Encounters vs Provider File	• Direction 1: Percentage of Providers in the Pharmacy Encounter File Who Were Also in the Provider File • Direction 2: Percentage of Providers in the Provider File Who Were Also in the Pharmacy Encounter File

Encounter Data Logic

Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), HSAG developed logic-based checks to ensure the encounter data could appropriately support additional activities.

- Continuous member enrollment to identify the length of time members were continuously enrolled during the measurement year. This assessment provides insight into how well encounter data may be used to support future analyses, such as HEDIS performance measure calculations. For instance, many measures require members be enrolled for the full measurement year, allowing only one gap of up to 45 days.

Description of Data Obtained and Related Time Period

Information Systems Review

Representatives from each MHP completed the MDHHS-approved questionnaire and then submitted their responses and relevant documents to HSAG for review. Of note, the questionnaire included an attestation statement for the MHP's chief executive officer or responsible individual to certify that the information provided was complete and accurate.

Administrative Profile

Data obtained from MDHHS included:

- Claims and encounter data with dates of service from October 1, 2021, through September 30, 2022.
- Member demographic and enrollment data.
- Provider data.

Process for Drawing Conclusions

Information Systems Review

HSAG compiled findings from the review of the received questionnaire responses, identifying critical points that affected the submission of quality encounter data. HSAG made conclusions based on CMS EQR Protocol 5, the MCO contract, MDHHS' data submission requirements (e.g., companion guides), and HSAG's experience working with other states regarding the IS review.

Administrative Profile

To draw conclusions about the quality of each MHP's encounter data submissions to MDHHS, HSAG evaluated the results based on the predefined study and/or key metrics described above. To identify strengths and weaknesses, HSAG assessed the results based on its experience in working with other states in assessing the completeness, accuracy, and timeliness of the MHP's encounter data submissions to MDHHS. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of encounter data submitted to MDHHS.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

The CAHPS surveys ask adult members and parents/caretaker of child members to report on and evaluate their experiences with healthcare. The surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys are recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (without the CCC measurement set) to the child Medicaid population for the adult and child Medicaid CAHPS surveys. For the CSHCS CAHPS survey, a modified version of the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set was used for data collection for the FFS and child Medicaid populations. For the HMP CAHPS survey, the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set was used to collect data for the adult HMP population. Various methods of data collection were used for the CAHPS surveys, such as mixed-mode (i.e., mailed surveys followed by telephone interviews of non-respondents), mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents), or mail-only. For the adult and child Medicaid CAHPS surveys, based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2022; and child members included as

eligible for the survey were 17 years of age or younger as of December 31, 2022. For the CSHCS CAHPS survey, child members included as eligible for the survey were 17 years of age or younger as of January 31, 2023. For the HMP CAHPS survey, adult members included as eligible for the survey were 19 years or older as of January 31, 2023.

The survey questions were categorized into various measures of member experience. For the adult and child Medicaid and HMP CAHPS surveys, these measures included four global ratings, four composite measures, and three items of the Medical Assistance with Smoking and Tobacco Use Cessation measure.[A-3] The global ratings reflected respondents' overall experience with their/their child's personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The Medical Assistance with Smoking and Tobacco Use Cessation measure items assessed the various aspects of providing assistance with smoking and tobacco use cessation in the adult population.

For the CSHCS CAHPS survey, these measures included four global rating questions, four composite measures, and five individual item measures. The global ratings reflected respondents' overall experience with the health plan, healthcare, specialists, and CMDS clinics. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Customer Service* and *How Well Doctors Communicate*). The individual item measures were individual questions that looked at specific areas of care (e.g., *Access to Prescription Medicines*).

NCQA requires a minimum of 100 respondents on each item to report the measure as a valid CAHPS survey result; however, for this report, if available, the MHPs' results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Measure results that did not meet the minimum number of 100 respondents are denoted in the tables with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

For each of the global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," or "Always." A positive or top-box response for the composites was defined as a response of "Always" or "Usually." The percentage of top-box responses is referred to as a top-box score for the composite measures. For the Medical Assistance with Smoking and Tobacco Use Cessation measure items, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results. Individual item measure question response choices were "Never," "Sometimes," "Usually," or "Always," and "Extremely Dissatisfied," "Somewhat Dissatisfied," "Neither Satisfied Nor Dissatisfied," "Somewhat Satisfied," or "Extremely Satisfied." A positive or top-box response for the individual items

[A-3] Medical Assistance with Smoking and Tobacco Use Cessation measure items related to smoking cessation were only included for the adult surveys.

was defined as a response of "Always" or "Usually" and "Somewhat Satisfied" or "Extremely Satisfied."

NCQA National Average Comparisons

Each MHP's 2023 adult and child CAHPS scores were compared to the 2022 NCQA adult and child Medicaid national averages, respectively.[A-4] A *t* test was performed to determine whether 2023 top-box scores were statistically significantly different from the 2022 NCQA adult and child Medicaid national averages. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than 0.05.

Colors and arrows and triangles are used to note statistically significant differences. An upward green (↑) arrow indicates a 2023 top-box score that was statistically significantly higher than the 2022 NCQA national average. A downward red (↓) arrow indicates a 2023 top-box score that was statistically significantly lower than the 2022 NCQA national average. 2023 scores that were not statistically significantly higher or lower than the 2022 NCQA national averages are not denoted with arrows.

Plan Comparisons

The results of the MHPs were compared to the applicable program (i.e., Medicaid managed care program, CSHCS managed care program, and HMP program). Two types of hypothesis tests were applied to these results. First, a global *F* test was calculated, which determined whether the difference between the MHPs' scores was significant. If the *F* test demonstrated plan-level differences (i.e., *p* value < 0.05), then a *t* test was performed for each MHP. The *t* test determined whether each MHP's score was statistically significantly different from the applicable program.

Colored arrows and triangles are used to note statistically significant differences. An upward green (↑) arrow indicates a 2023 top-box score that was statistically significantly higher than the applicable program's 2023 top-box score. A downward red (↓) arrow indicates a 2023 top-box score that was statistically significantly lower than the applicable program's 2023 top-box score. The 2023 top-box scores that were not statistically significantly higher or lower than the applicable program are not denoted with arrows. An upward green (▲) triangle indicates a 2023 top-box score was statistically significantly higher than the 2022 top-box score. A downward red (▼) triangle indicates a 2023 top-box score was statistically significantly lower than the 2022 top-box score. The 2023 top-box scores that were not statistically significantly higher or lower than the 2022 top-box scores are not denoted with triangles. For CSHCS, an upward green (▲) triangle also indicates the 2023 CSHCS Managed Care Program average as statistically significantly higher than the 2022 CSHCS Managed Care Program average and a downward red (▼) triangle indicates the 2023 CSHCS Managed Care Program average as statistically significantly lower than the 2022 CSHCS Managed Care Program average.

[A-4] National Committee for Quality Assurance. *Quality Compass: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

Description of Data Obtained and Related Time Period

HSAG administered the CAHPS surveys to the child Medicaid population for the MHPs, child members enrolled in CSHCS, and adult members enrolled in HMP. The MHPs provided HSAG with the adult Medicaid CAHPS survey data presented in this report. The MHPs reported that NCQA protocols were followed for administering the CAHPS surveys.

The CAHPS 5.1H Child Medicaid Health Plan Survey was administered to parents/caretakers of child members enrolled in the MHPs from February to May 2023. The CSHCS CAHPS survey was administered to parents/caretakers of child members enrolled in the CSHCS Program from June to September 2023. The HMP CAHPS survey was administered to eligible adult members in the HMP from June to September 2023.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of services provided by the MHPs, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table A-9.

Table A-9—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Adult and Child Medicaid/HMP			
Global Ratings			
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Composite Measures			
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
*Transportation**	✓		✓
Individual Item Measure			
Coordination of Care	✓		
Medical Assistance With Smoking and Tobacco Use Cessation			
Advising Smokers and Tobacco Users to Quit	✓		
Discussing Cessation Medications	✓		
Discussing Cessation Strategies	✓		

CAHPS Topic	Quality	Timeliness	Access
CSHCS			
Global Ratings			
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Specialist Seen Most Often	✓		
Rating of CMDS Clinic	✓		
Composite Measures			
Customer Service	✓		
How Well Doctors Communicate	✓		
Access to Specialized Services			✓
*Transportation**	✓		✓
Individual Item Measures			
Access to Prescription Medicines			✓
CMDS Clinics	✓	✓	
Local Health Department Services	✓		
Not Felt Treated Unfairly: Race and Ethnicity	✓		
Not Felt Treated Unfairly: Health Insurance Type	✓		

*Transportation is a child composite measure presented in the 2023 Child Medicaid CAHPS Report and 2023 CHSCS CAHPS Report. Transportation results are not presented in Section 3 because the supplemental survey questions that make up the composite measure are not included in the standard CAHPS 5.1H Child Medicaid Health Plan Survey; therefore, a 2022 and 2023 NCQA benchmark is not available for this measure.

Quality Rating

Activity Objectives

MDHHS contracted with HSAG to analyze MY 2022 HEDIS results, including MY 2022 CAHPS data from the nine MHPs for presentation in the 2023 Michigan Consumer Guide. The 2023 Michigan Consumer Guide analysis helps to support MDHHS' public reporting of health plan performance information.

Technical Methods of Data Collection and Analysis

MDHHS, in collaboration with HSAG, chose measures for the 2023 Michigan Consumer Guide based on a number of factors that were consistent with previous years. Per NCQA specifications, the CAHPS 5.1H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.1H Child Medicaid Health Plan Survey instrument was used for the child population.

Table A-10 lists the 40 measures, 15 CAHPS and 25 HEDIS, and their associated weights.[A-5] The measures are organized by reporting category and subcategory.

Table A-10— MDHHS MHP Consumer Guide Reporting Categories, Subcategories, Measures, and Weights

Measures	Measure Weight
Overall Rating [A-6]	
Adult Medicaid—*Rating of Health Plan* (CAHPS Global Rating)	1
Child Medicaid—*Rating of Health Plan* (CAHPS Global Rating)	1
Adult Medicaid—*Rating of All Health Care* (CAHPS Global Rating)	1
Child Medicaid—*Rating of All Health Care* (CAHPS Global Rating)	1
Doctors' Communication and Service	
Satisfaction With Providers	
Adult Medicaid—*How Well Doctors Communicate* (CAHPS Composite)	1
Child Medicaid—*How Well Doctors Communicate* (CAHPS Composite)	1
Adult Medicaid—*Rating of Personal Doctor* (CAHPS Global Rating)	1
Child Medicaid—*Rating of Personal Doctor* (CAHPS Global Rating)	1
Patient Engagement	
Medical Assistance With Smoking and Tobacco Use Cessation	
Advising Smokers and Tobacco Users to Quit	1/3
Discussing Cessation Medications	1/3
Discussing Cessation Strategies	1/3
Getting Care	
Access	
Adult Medicaid—*Getting Needed Care* (CAHPS Composite)	1
Child Medicaid—*Getting Needed Care* (CAHPS Composite)	1
Adult Medicaid—*Getting Care Quickly* (CAHPS Composite)	1
Child Medicaid—*Getting Care Quickly* (CAHPS Composite)	1
Adults' Access to Preventive/Ambulatory Health Services	
Ages 20–44 Years	1/3
Ages 45–64 Years	1/3

[A-5] Four measures, Adult Medicaid—*Customer Service (CAHPS Composite)*, Child Medicaid—*Customer Service (CAHPS Composite)*, Adult Medicaid—*Rating of Specialist Seen Most Often (CAHPS Global Rating)*, and Child Medicaid—*Rating of Specialist Seen Most Often (CAHPS Global Rating)*, were excluded from the 2023 Consumer Guide based on insufficient data reported by more than half of the MHPs.

[A-6] To calculate the Overall Rating category, all 40 CAHPS and HEDIS measures are included in the analysis. Please note that the CAHPS measures listed in the Overall Rating reporting category are exclusive to the reporting category.

Measures	Measure Weight
Ages 65+ Years	1/3
Keeping Kids Healthy	
Immunizations and Screenings for Young Children	
Childhood Immunization Status	
Combination 3	1
Lead Screening in Children	1
Immunizations for Adolescents	
Immunizations for Adolescents	
Combination 2	1
Preventive Care	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
Body Mass Index (BMI) Percentile Documentation—Total	1/3
Counseling for Nutrition—Total	1/3
Counseling for Physical Activity—Total	1/3
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	1
Well-Child Visits for Ages 15 Months–30 Months—Two or More Well-Child Visits	1
Child and Adolescent Well-Care Visits	
Ages 3–11 Years	1
Ages 12–17 Years	1
Ages 18–21 Years	1
Living With Illness	
Diabetes	
Blood Pressure Control for Patients With Diabetes	1/4
Eye Exam for Patients with Diabetes	1/4
Hemoglobin A1c Control for Patients With Diabetes	
HbA1c Control (<8.0%)	1/4
HbA1c Poor Control (>9.0%)	1/4
Cardiovascular	
Controlling High Blood Pressure	1
Respiratory	
Asthma Medication Ratio—Total	1

Measures	Measure Weight
Taking Care of Women	
Screenings for Women	
Breast Cancer Screening	1
Cervical Cancer Screening	1
Chlamydia Screening in Women—Total	1
Maternal Health	
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	1
Postpartum Care	1

HSAG computed six reporting category and 11 subcategory summary scores for each MHP, as well as the summary mean values for the MHPs as a group. Each score is a standardized score where higher values represent more favorable performance. Summary scores for the six reporting categories (Overall Rating, Doctors' Communication and Service, Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women) and 11 subcategories (Satisfaction With Providers, Patient Engagement, Access, Immunizations and Screenings for Young Children, Immunizations for Adolescents, Preventive Care, Diabetes, Cardiovascular, Respiratory, Screenings for Women, and Maternal Health) were calculated from MHP scores on select HEDIS measures and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets, and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, HSAG converted each individual question by assigning the top-box responses (i.e., "Usually/Always" and "9/10," where applicable) to a "1" for each individual question, as described in *HEDIS Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of "0." HSAG then calculated the percentage of respondents with a top-box response (i.e., a "1"). For composite measures, HSAG calculated the composite rate by taking the average percentage for each question within the composite.

2. For each HEDIS and CAHPS measure, HSAG calculated the measure variance. The measure variance for HEDIS measures was calculated as follows:

$$\frac{p_k(1-p_k)}{n_k-1}$$

where: p_k = MHP k score
n_k = number of members in the measure sample for MHP k

For CAHPS global rating measures, the variance will be calculated as follows:

$$\frac{1}{n}\frac{\sum_{i=1}^{n}(x_i-\bar{x})^2}{n-1}$$

where: x_i = response of member i
$\bar{x}$ = the mean score for MHP k
n = number of responses in MHP k

For CAHPS composite measures, the variance will be calculated as follows:

$$\frac{N}{N-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij}-\bar{x}_j)}{n_j}\right)^2$$

where: $j = 1,\ldots,m$ questions in the composite measure
$i = 1\ldots.,n_j$ members responding to question j
x_{ij} = response of member i to question j (0 or 1)
$\bar{x}_j$ = MHP mean for question j
N = members responding to at least one question in the composite

3. For MHPs with *NR*, *BR*, and *NA* audit results, HSAG used the average variance of the non-missing rates across all MHPs. This ensured that all rates reflect some level of variability, rather than simply omitting the missing variances in subsequent calculations.

4. HSAG computed the MHP mean for each CAHPS and HEDIS measure.

5. Each MHP mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MHP means and dividing by the standard deviation of the MHP means to give each measure equal weight toward the category rating. If the measures are not standardized, a measure with higher variability would contribute disproportionately toward the category rating.

6. HSAG summed the standardized MHP means, weighted by the individual measure weights to derive the MHP category summary measure score.

7. For each MHP *k*, HSAG calculated the category variance, CV_k, as: $CV_k = \sum_{j=1}^{m}\frac{w_j}{c_j^2}V_j$

where: $j = 1,\ldots,m$ HEDIS or CAHPS measures in the summary
V_j = variance for measure j
c_j = group standard deviation for measure j
w_j = measure weight for measure j

8. The summary scores were used to compute the group mean and the difference scores. The group mean was the average of the MHP summary measure scores. The difference score, d_k, was calculated as d_k = MHP k score – group mean.

9. For each MHP k, HSAG calculated the variance of the difference scores, $Var(d_k)$, as:

$$Var(d_k) = \frac{P(P-2)}{P^2} CV_k + \frac{1}{P^2} \sum_{k=1}^{P} CV_k$$

where: P = total number of MHPs
CV_k = category variance for MHP k

10. The statistical significance of each difference was determined by computing a confidence interval (CI). A 95 percent CI was calculated around each difference score to identify MHPs that were significantly higher than or significantly lower than the mean. MHPs with differences significantly above or below zero at the 95 percent confidence level received the top (Above Average) and bottom (Below Average) designations, respectively. An MHP was significantly above zero if the lower limit of the CI was greater than zero and was significantly below zero if the upper limit of the CI was below zero. MHPs that did not fall either above or below zero at the 95 percent confidence level received the middle designation (Average). For a given measure, the formula for calculating the 95 percent CI was:

$$95\%\ \text{CI} = d_k \pm 1.96\sqrt{Var(d_k)}$$

A three-level rating scale provides consumers with an easy-to-read "picture" of quality performance across the MHPs and presents data in a manner that emphasizes meaningful differences between the MHPs. The 2023 Michigan Consumer Guide used apples to display results for each MHP.

Description of Data Obtained and Related Time Period

HEDIS MY 2022 rates were extracted from the auditor-locked IDSS data sets, and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files.

Appendix B. 2023 HEDIS Aggregate Report for Michigan Medicaid

Appendix B presents the final *2023 HEDIS Aggregate Report for Michigan Medicaid*.

Michigan Department of Health & Human Services

GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

2023 HEDIS Aggregate Report for Michigan Medicaid

October 2023

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

During 2022, the Michigan Department of Health and Human Services (MDHHS) contracted with nine health plans to provide managed care services to Michigan Medicaid members. MDHHS expects its contracted Medicaid health plans (MHPs) to support claims systems, membership and provider files, as well as hardware/software management tools that facilitate valid reporting of the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] measures. MDHHS contracted with Health Services Advisory Group, Inc. (HSAG), to calculate statewide average rates based on the MHPs' rates and evaluate each MHP's current performance level, as well as the statewide performance, relative to national Medicaid percentiles.

MDHHS selected HEDIS measures to evaluate Michigan MHPs within the following eight measure domains:

- Child & Adolescent Care
- Women—Adult Care
- Access to Care
- Obesity
- Pregnancy Care
- Living With Illness
- Health Plan Diversity
- Utilization

Of note, all measures in the Health Plan Diversity domain and some measures in the Utilization domain are provided within this report for information only as they assess the health plans' use of services and/or describe health plan characteristics and are not related to performance. Therefore, most of these rates were not evaluated in comparison to national percentiles, and changes in these rates across years were not analyzed by HSAG for statistical significance.

The performance levels are based on national percentiles and were set at specific, attainable rates. MHPs that met the high performance level (HPL) exhibited rates that were among the 90th percentile in comparison to the national average. The low performance level (LPL) was set to identify MHPs that were among the 25th percentile in comparison to the national average and have the greatest need for improvement. Details describing these performance levels are presented in Section 2, "How to Get the Most From This Report."

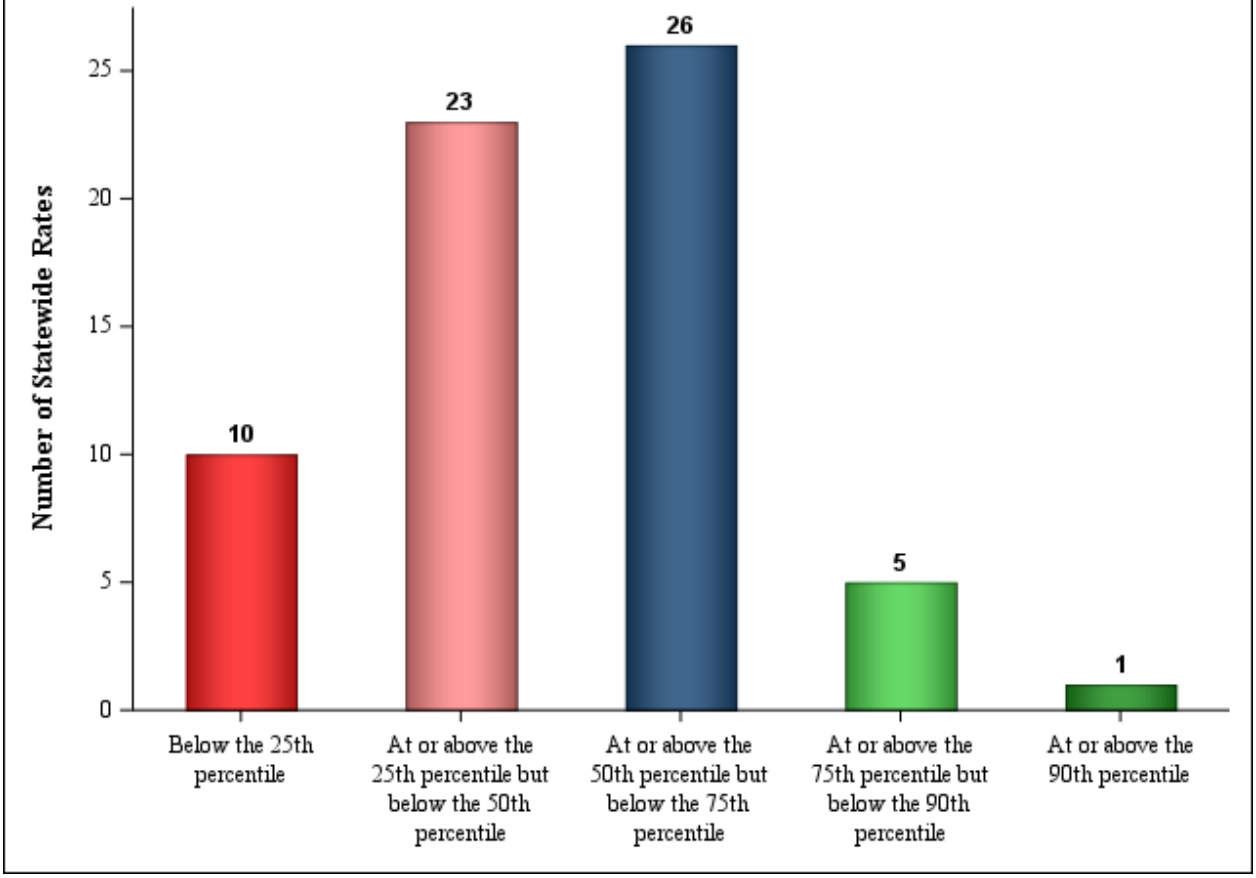
[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

In addition, Section 11 ("HEDIS Reporting Capabilities—Information Systems Findings") provides a summary of the HEDIS data collection processes used by the Michigan MHPs and the audit findings in relation to the National Committee for Quality Assurance's (NCQA's) information system (IS) standards.[1-2]

Summary of Performance

Figure 1-1 compares the Michigan Medicaid program's overall rates with NCQA's Quality Compass® national Medicaid HMO percentiles for HEDIS MY 2022, which are referred to as "percentiles" throughout this report.[1-3] For measures that were comparable to percentiles, the bars represent the number of Michigan Medicaid Weighted Average (MWA) measure indicator rates that fell into each percentile range.

Figure 1-1—Michigan Medicaid Statewide Averages Compared to National Medicaid Percentiles



[1-2] National Committee for Quality Assurance. *HEDIS® MY 2022, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C.

[1-3] Quality Compass® is a registered trademark for the NCQA.

Of the 65 reported rates that were comparable to national Medicaid percentiles, 10 of the MWA rates fell below the 25th percentile and a total of 33 rates (about 51 percent) were below the 50th percentile. These results demonstrate a general statewide decline in performance in comparison to the MY 2021 rates, which showed approximately 37 percent of the rates falling below the 50th percentile. A summary of MWA performance for each measure domain is presented on the following pages.

Child & Adolescent Care

For the Child & Adolescent Care domain, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*; *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years* and *Total*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicators were an area of strength. All measure indicators ranked at or above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2021 MWA. Priority, Upper Peninsula, Blue Cross, Molina, and Meridian ranked above the 50th percentile for the most measure indicators within the Child & Adolescent Care domain. Upper Peninsula and Blue Cross ranked above the HPL for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, and Upper Peninsula ranked above the HPL for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator.

The MWA demonstrated a significant decline for *Childhood Immunization Status—Combination 10*; *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years*; and *Immunizations for Adolescents—Combination 2* indicators. The MWA for the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* indicators had an MWA decrease of nearly 2 percentage points and over 3 percentage points, respectively, from HEDIS MY 2021, and ranked below the 25th percentile.

MDHHS should continue to monitor the MHPs' performance on the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measure indicators to ensure that the MHPs' performance does not continue to decline, while working with the MHPs and providers to target improving child and adolescent vaccination rates. Immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[1-4] The identified declines in routine pediatric vaccine ordering and doses administered might indicate that children in the United States and their communities face increased risks for outbreaks of vaccine-preventable diseases. Reminding parents of the vital need to protect their children against serious vaccine-preventable diseases, even as coronavirus disease 2019 (COVID-19) continues to be a health concern, is critical. Children who are not protected by vaccines will be more vulnerable to communicable and preventable diseases such as measles. In response, continued coordinated efforts between healthcare providers and

[1-4] National Committee for Quality Assurance. Childhood Immunization Status. Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Aug 31, 2023.

public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[1-5]

Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* measure indicator. Assessing physical, emotional, and social development is important at every stage of life, particularly with children and adolescents. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[1-6] Well-care visits between the ages of 18 and 21 years can also assist in the successful transition from pediatric to adult-oriented healthcare to ensure ongoing medical treatment, as needed. The goal of a planned healthcare transition is to maximize lifelong functioning and well-being for all youth, including those who have special health care needs (SHCN) and those who do not. This process includes ensuring that high-quality, developmentally appropriate healthcare services are available and uninterrupted as the person moves from adolescence to adulthood. A well-timed transition from child- to adult-oriented healthcare is specific to each person and ideally occurs between the ages of 18 and 21 years. Coordination of patient, family, and provider responsibilities enables youth to optimize their ability to assume adult roles and activities. [1-7]

Women—Adult Care

For the Women—Adult Care domain, the *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total; Cervical Cancer Screening*; and *Breast Cancer Screening* measure indicators were all an area of strength. All measure indicators ranked at or above the 50th percentile, with the *Chlamydia Screening in Women—Total* measure indicator ranking at or above the 75th percentile. Additionally, all measure indicators demonstrated significant improvement from the HEDIS MY 2021 MWA. Blue Cross, Meridian, Molina, Priority, and UnitedHealthcare ranked above the 50th percentile for the most measure indicators within the Women—Adult Care domain. In addition, Meridian ranked above the HPL for the *Chlamydia Screening in Women—21 to 24 Years* measure indicator.

While none of the measure indicators in the Women—Adult Care domain demonstrated a significant decline in the MWA from HEDIS MY 2021, one MHP demonstrated a statistically significant decline in MY 2022 for the *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Total,* and *Breast Cancer Screening* measure indicators. MDHHS should continue to monitor the MHPs' performance related to these measure indicators within the Women—Adult Care domain to maintain and further improve performance. It has been widely researched and validated that screening can improve outcomes and

[1-5] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Aug 31, 2023.

[1-6] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Aug 31, 2023.

[1-7] American Academy of Pediatrics. Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home. Available at: https://publications.aap.org/pediatrics/article/128/1/182/30310/Supporting-the-Health-Care-Transition-From?autologincheck=redirected. Accessed on: August 31, 2023.

early detection, reduce the risk of dying, and lead to a greater range of treatment options and lower healthcare costs.[1-8] A reduction in patient structural barriers (such as office hours, scheduling assistance, translation services, and decreasing the number of clinic visits) could potentially further increase access to and utilization of needed screenings.[1-9]

Access to Care

For the Access to Care domain, the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* and *Appropriate Testing for Pharyngitis—Total* measure indicators demonstrated significant improvement from the HEDIS MY 2021 MWA. Upper Peninsula, Priority, and Meridian ranked above the 50th percentile for the most measure indicators within the Access to Care domain. In addition, Upper Peninsula ranked above the HPL for *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older,* and *Appropriate Testing for Pharyngitis—Ages 18–64 Years* and *Total* measure indicators.

The MWA demonstrated a significant decline for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*, *Ages 45 to 64 Years*, and *Total; Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years*; and *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years*, *Ages 18 to 64 Years*, and *Total* measure indicators. The measure indicator with the most significant decline was *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years,* with an MWA decrease of 5 percentage points from HEDIS MY 2021. Additionally, the MWA ranked below the 25th percentile for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older* and *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years* measure indicators with no significant improvement.

MDHHS should conduct ongoing monitoring of the MHPs' performance and declining rates across the Access to Care domain. Underperforming MHPs for this domain should be given suggested interventions, based on MHP-specific capabilities, to improve rates. Improved rates for *Adults' Access to Preventive/Ambulatory Health Services*, *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*, *Appropriate Testing for Pharyngitis*, and *Appropriate Treatment for Upper Respiratory Infection* would have a positive impact on member healthcare outcomes. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help address acute issues or manage chronic conditions.[1-10] Antibiotic-resistant infections can lead to increased healthcare costs, and most importantly, to increased morbidity and mortality. The most important modifiable risk factor for antibiotic resistance is

[1-8] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Aug 31, 2023.

[1-9] Centers for Disease Control and Prevention. Reducing Structural Barriers Planning Guide. Available at: https://www.cdc.gov/screenoutcancer/ebi-planning-guides/reducing-structural-barriers-planning-guide.htm Accessed on: Aug 31, 2023.

[1-10] National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services. Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Sept 1, 2023.

inappropriate prescribing of antibiotics.[1-11] Proper testing and treatment of pharyngitis prevents the spread of sickness while reducing unnecessary use of antibiotics.[1-12]

Obesity

For the Obesity domain, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Counseling for Physical Activity—Total* measure indicators were an area of strength. Both measure indicators ranked at or above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2021 MWA. Additionally, Upper Peninsula, Blue Cross, Priority, UnitedHealthcare, Aetna, and HAP ranked above the 50th percentile for the most measure indicators within the Obesity domain. Priority and Upper Peninsula ranked above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator.

While the MY 2022 MWA for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator significantly increased from the MY 2021 MWA, it ranked below the 50th percentile, demonstrating an area for further improvement. Additionally, McLaren fell below the LPL for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators.

MDHHS should continue to monitor the MHPs' performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator and work with the MHPs and providers to strategize the best way to utilize every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, MDHHS should continue to monitor McLaren's performance for this measure to ensure the MHP's performance does not continue to decline and encourage higher-performing MHPs to share and discuss best practices. Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases. Obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents and provide guidance for maintaining a healthy weight and lifestyle.[1-13]

Pregnancy Care

For the Pregnancy Care domain, *Prenatal and Postpartum Care—Postpartum Care* was an area of strength, as the measure indicator demonstrated significant improvement from the HEDIS MY 2021 MWA. Additionally, Upper Peninsula, Blue Cross, and Priority ranked above the 50th percentile for at

[1-11] Centers for Disease Control and Prevention. Core Elements of Outpatient Antibiotic Stewardship. Available at: https://www.cdc.gov/antibiotic-use/core-elements/outpatient.html. Accessed on: Sept 1, 2023.
[1-12] National Committee for Quality Assurance. Appropriate Testing for Pharyngitis. Available at: https://www.ncqa.org/hedis/measures/appropriate-testing-for-children-with-pharyngitis/. Accessed on: Sept 12, 2023.
[1-13] National Committee for Quality Assurance. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. Available at: https://www.ncqa.org/hedis/measures/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents/. Accessed on: Sept 1, 2023.

least one of the measure indicators within the Pregnancy Care domain, with Upper Peninsula ranking above the HPL for both *Timeliness of Prenatal Care and Postpartum Care* measure indicators.

Molina, Priority, UnitedHealthcare, HAP, Meridian, McLaren, and Aetna all fell below the LPL for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; and Molina, HAP, and Aetna all fell below the LPL for *Prenatal and Postpartum Care—Postpartum Care*.

Timely and adequate prenatal and postpartum care can set the stage for long-term health and well-being of new mothers and their infants.[1-14] MDHHS should continue monitoring the MHPs' performance in the Pregnancy Care domain and assess the need for or evaluation of current prenatal and postpartum care coordination programs for lower-performing MHPs. Effective care coordination efforts or programs could potentially assist with scheduling prenatal and postpartum appointments, arranging transportation, and educating members on the importance of keeping appointments. MDHHS is also encouraged to work with the higher-performing MHPs to identify best practices for ensuring women's access to prenatal and postpartum care which can then be shared with the lower-performing MHPs to improve overall access.

Living With Illness

For the Living With Illness domain, the *Hemoglobin A1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%)* and *HbA1c Control (<8.0%)*; *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)*; *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years*, *Ages 65 to 74 Years*, and *Total*; *Controlling High Blood Pressure*; and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators were areas of significant strength. Most of these measure indicators ranked at or above the 50th percentile, with the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators ranking at or above the 75th and 90th percentiles, respectively. All of these measure indicators also demonstrated significant improvement from the HEDIS MY 2021 MWA. Upper Peninsula, Priority, and UnitedHealthcare ranked above the 50th percentile and the HPL for the most measure indicators within the Living With Illness domain.

While the HEDIS MY 2022 MWA demonstrated considerable improvement from HEDIS MY 2021 across the Living With Illness domain, the *Asthma Medication Ratio* measure indicator ranked below the 25th percentile, demonstrating an area for improvement. MDHHS is encouraged to continue monitoring MHPs' quality improvement strategies for the Living With Illness domain. MDHHS should work with the MHPs to readily identify interventions and operational process changes that led to increased rates, while supporting and strengthening methods that resulted in improved year-over-year performance. Additionally, the MHPs should focus their efforts on improving performance related to the *Asthma Medication Ratio* measure indicator and health outcomes among people with asthma. The prevalence

[1-14] National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Sept 1, 2023.

and cost of asthma has increased over the past decade, demonstrating the need for better access to care and medication. Appropriate medication management for patients with asthma could reduce the need for rescue medication, as well as the costs associated with emergency room visits, inpatient admissions, and missed days of work or school.[1-15]

Health Plan Diversity

Although measures under this domain are not performance measures and are not compared to percentiles, changes observed in the results may provide insight into how select member characteristics affect the MHPs' provision of services and care.

Utilization

For the *Ambulatory Care—Emergency Department (ED) Visits—Total* measure indicator, the Michigan Medicaid Average (MA) increased by 36.1 visits per 1,000 member years from HEDIS MY 2020 to HEDIS MY 2022. The MA for the *Outpatient Visits—Total* measure indicator increased from HEDIS MY 2020 to HEDIS MY 2022 by 555.63 visits per 1,000 member years.[1-16] Since the measure of outpatient visits is not linked to performance, the results for this measure are not comparable to percentiles. For the *Plan All-Cause Readmissions* measure, six MHPs had an O/E ratio less than 1.0, indicating that these MHPs had fewer observed readmissions than were expected based on patient mix. The remaining three MHPs' O/E ratio is more than 1.0 indicating they had more readmissions.

Limitations and Considerations

Some behavioral health services are carved out and are not provided by the MHPs; therefore, exercise caution when interpreting rates for measures related to behavioral health.

[1-15] National Committee for Quality Assurance. Asthma Medication Ratio. Available at: https://www.ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio/. Accessed on: Sept 1, 2023.

[1-16] For the *ED Visits* indicator, awareness is advised when interpreting results for this indicator as a lower rate is a higher percentile.

2. How to Get the Most From This Report

Introduction

This reader's guide is designed to provide supplemental information to the reader that may aid in the interpretation and use of the results presented in this report.

Michigan Medicaid Health Plan Names

Table 2-1 presents a list of the Michigan MHPs discussed within this report and their corresponding abbreviations.

Table 2-1—2023 Michigan MHP Names and Abbreviations

MHP Name	Short Name	Abbreviation
Aetna Better Health of Michigan	Aetna	AET
Blue Cross Complete of Michigan	Blue Cross	BCC
McLaren Health Plan	McLaren	MCL
Meridian Health Plan of Michigan	Meridian	MER
HAP Empowered*	HAP	HAP
Molina Healthcare of Michigan	Molina	MOL
Priority Health	Priority	PRI
UnitedHealthcare Community Plan	UnitedHealthcare	UNI
Upper Peninsula Health Plan	Upper Peninsula	UPP

**Of note, as of October 1, 2023, HAP Empowered transitioned to HAP CareSource.*

Summary of Michigan Medicaid HEDIS MY 2022 Measures

Within this report, HSAG presents the Michigan MWA (i.e., statewide average rates) and MHP-specific performance on HEDIS measures selected by MDHHS for HEDIS MY 2022. These measures were grouped into the following eight domains of care: Child & Adolescent Care, Women—Adult Care, Access to Care, Obesity, Pregnancy Care, Living With Illness, Health Plan Diversity, and Utilization. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages MHPs and MDHHS to consider the measures as a whole rather than in isolation and to develop the strategic changes required to improve overall performance.

Table 2-2 shows the selected HEDIS MY 2022 measures and measure indicators as well as the corresponding domains of care and the reporting methodologies for each measure. The data collection or calculation method is specified by NCQA in the *HEDIS MY 2022 Volume 2 Technical Specifications*. Data collection methodologies are described in detail in the next section.

Table 2-2—Michigan Medicaid HEDIS MY 2022 Required Measures

Performance Measures	HEDIS Data Collection Methodology
Child & Adolescent Care	
Childhood Immunization Status	
Combination 3	Hybrid
Combination 7	Hybrid
Combination 10	Hybrid
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	Administrative
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	Administrative
Lead Screening in Children	
Lead Screening in Children	Hybrid
Child and Adolescent Well-Care Visits	
Ages 3 to 11 Years	Administrative
Ages 12 to 17 Years	Administrative
Ages 18 to 21 Years	Administrative
Total	Administrative
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	Hybrid
Combination 2 (Meningococcal, Tdap, HPV)	Hybrid
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	
Initiation Phase	Administrative
Continuation and Maintenance Phase	Administrative
Women—Adult Care	
Chlamydia Screening in Women	
Ages 16 to 20 Years	Administrative
Ages 21 to 24 Years	Administrative
Total	Administrative

Performance Measures	HEDIS Data Collection Methodology
Cervical Cancer Screening	
Cervical Cancer Screening	Hybrid
Breast Cancer Screening	
Breast Cancer Screening	Administrative
Access to Care	
Adults' Access to Preventive/Ambulatory Health Services	
Ages 20 to 44 Years	Administrative
Ages 45 to 64 Years	Administrative
Ages 65 Years and Older	Administrative
Total	Administrative
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	
Ages 3 Months to 17 Years	Administrative
Ages 18 to 64 Years	Administrative
Ages 65 Years and Older	Administrative
Total	Administrative
Appropriate Testing for Pharyngitis[1]	
Ages 3 to 17 Years	Administrative
Ages 18 to 64 Years	Administrative
Age 65 Years and Older	Administrative
Total	Administrative
Appropriate Treatment for Upper Respiratory Infection	
Ages 3 Months to 17 Years	Administrative
Ages 18 to 64 Years	Administrative
Ages 65 Years and Older	Administrative
Total	Administrative
Obesity	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
Body Mass Index (BMI) Percentile—Total	Hybrid
Counseling for Nutrition—Total	Hybrid
Counseling for Physical Activity—Total	Hybrid

Performance Measures	HEDIS Data Collection Methodology
Pregnancy Care	
Prenatal and Postpartum Care	
Timeliness of Prenatal Care[1]	Hybrid
Postpartum Care	Hybrid
Living With Illness	
Hemoglobin A1c Control for Patients With Diabetes	
*Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**	Hybrid
HbA1c Control (<8.0%)	Hybrid
Blood Pressure Control for Patients With Diabetes	
Blood Pressure Control for Patients With Diabetes	Hybrid
Eye Exam for Patients With Diabetes	
Eye Exam for Patients With Diabetes	Hybrid
Kidney Health Evaluation for Patients With Diabetes	
Ages 18 to 64 Years	Administrative
Ages 65 to 74 Years	Administrative
Ages 75 to 85 Years	Administrative
Total	Administrative
Asthma Medication Ratio	
Total	Administrative
Controlling High Blood Pressure	
Controlling High Blood Pressure	Hybrid
Antidepressant Medication Management	
Effective Acute Phase Treatment	Administrative
Effective Continuation Phase Treatment	Administrative
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Administrative
Diabetes Monitoring for People With Diabetes and Schizophrenia	
Diabetes Monitoring for People With Diabetes and Schizophrenia	Administrative
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Administrative

Performance Measures	HEDIS Data Collection Methodology
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Administrative
Health Plan Diversity	
Race/Ethnicity Diversity of Membership	
White	Administrative
Black or African-American	Administrative
American Indian or Alaska Native	Administrative
Asian	Administrative
Native Hawaiian and Other Pacific Islander	Administrative
Some Other Race	Administrative
Two or More Races	Administrative
Ethnicity Reporting Category: Hispanic or Latino	Administrative
Unknown	Administrative
Declined	Administrative
Language Diversity of Membership	
Spoken Language Preferred for Health Care—English	Administrative
Spoken Language Preferred for Health Care—Non-English	Administrative
Spoken Language Preferred for Health Care—Unknown	Administrative
Spoken Language Preferred for Health Care—Declined	Administrative
Language Preferred for Written Materials—English	Administrative
Language Preferred for Written Materials—Non-English	Administrative
Language Preferred for Written Materials—Unknown	Administrative
Language Preferred for Written Materials—Declined	Administrative
Other Language Needs—English	Administrative
Other Language Needs—Non-English	Administrative
Other Language Needs—Unknown	Administrative
Other Language Needs—Declined	Administrative
Utilization	
Ambulatory Care	
Emergency Department Visits$^{\pm}$	Administrative
Outpatient Visits	Administrative
Inpatient Utilization—General Hospital/Acute Care	
Discharges—Total Inpatient—Total All Ages	Administrative

Performance Measures	HEDIS Data Collection Methodology
Average Length of Stay—Total Inpatient—Total All Ages	Administrative
Discharges—Maternity—Total All Ages	Administrative
Average Length of Stay—Maternity—Total All Ages	Administrative
Discharges—Surgery—Total All Ages	Administrative
Average Length of Stay—Surgery—Total All Ages	Administrative
Discharges—Medicine—Total All Ages	Administrative
Average Length of Stay—Medicine—Total All Ages	Administrative
Use of Opioids From Multiple Providers*	
Multiple Prescribers	Administrative
Multiple Pharmacies	Administrative
Multiple Prescribers and Multiple Pharmacies	Administrative
Use of Opioids at High Dosage*	
Use of Opioids at High Dosage	Administrative
Risk of Continued Opioid Use*	
At Least 15 Days Covered—Total	Administrative
At Least 31 Days Covered—Total	Administrative
Plan All-Cause Readmissions*	
Observed Readmissions—Total	Administrative
Expected Readmissions—Total	Administrative
O/E Ratio—Total	Administrative

** For this indicator, a lower rate indicates better performance.*

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.

± Awareness is advised when interpreting results for this indicator as a lower rate is a higher percentile.

Data Collection Methods

Administrative Method

The administrative method requires that MHPs identify the eligible population (i.e., the denominator) using administrative data, derived from claims and encounters. In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely using administrative data collected during the reporting year. Medical record review data from the prior year may be used as supplemental data. Medical records collected during the current year cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed.

Hybrid Method

The hybrid method requires that MHPs identify the eligible population using administrative data and then extract a systematic sample of members from the eligible population, which becomes the denominator. Administrative data are used to identify services provided to those members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces higher rates because the completeness of documentation in the medical record exceeds what is typically captured in administrative data; however, the medical record review component of the hybrid method is considered more labor intensive. For example, the MHP has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure and chooses to use the hybrid method. After randomly selecting 411 eligible members, the MHP finds that 161 members had evidence of a postpartum visit using administrative data. The MHP then obtains and reviews medical records for the 250 members who did not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 were found to have a postpartum visit recorded in the medical record review. Therefore, the final rate for this measure, using the hybrid method, would be (161 + 54)/411, or 52.3 percent, a 13.1 percentage point increase from the administrative only rate of 39.2 percent.

Understanding Sampling Error

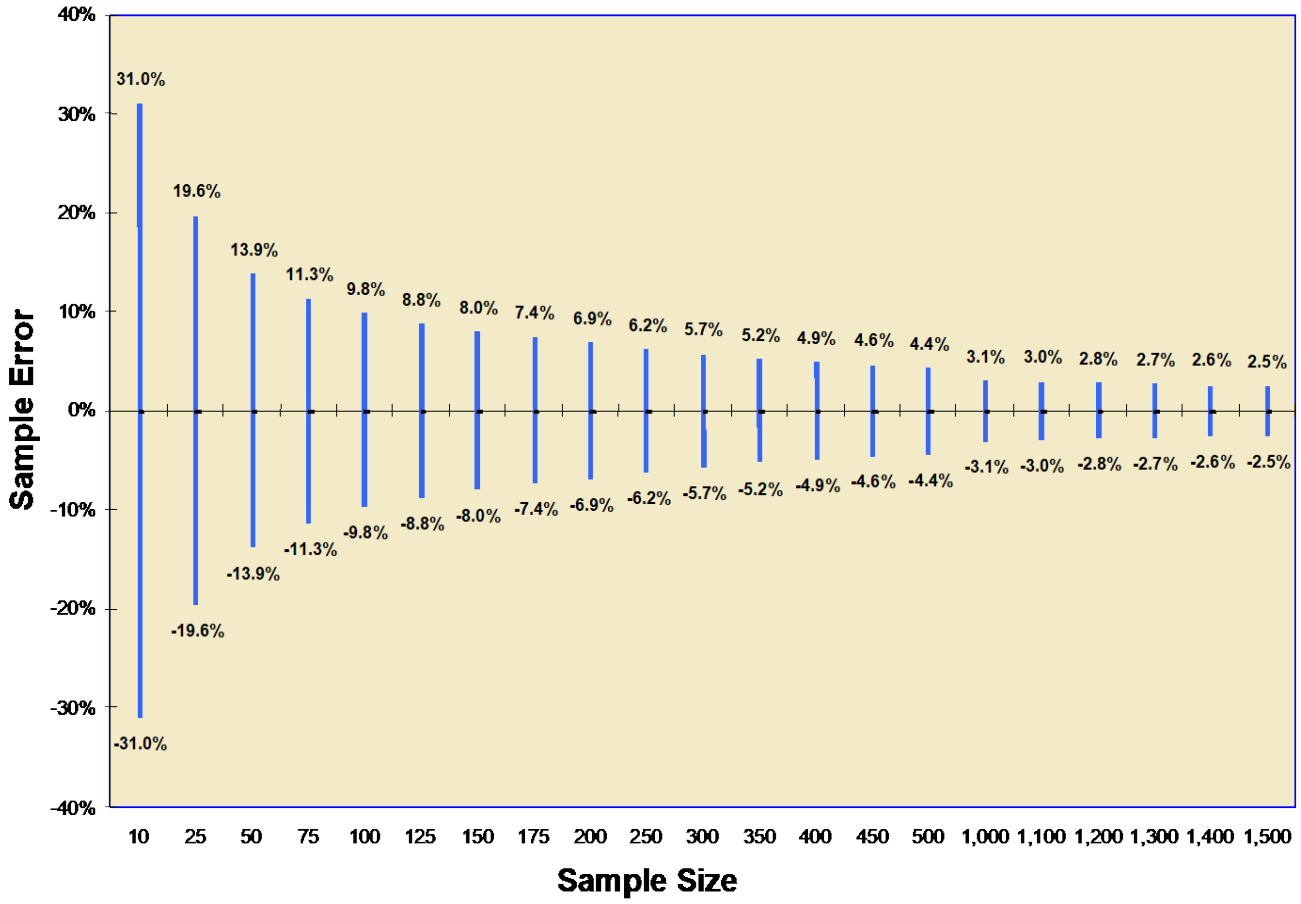
Correct interpretation of results for measures collected using HEDIS hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to complete medical record review for the entire eligible population for a given measure. Measures collected using the HEDIS hybrid method include only a sample from the eligible population, and statistical techniques are used to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire eligible population, the process of sample selection must be such that everyone in the eligible population has an equal chance of being selected. The HEDIS hybrid method prescribes a systematic sampling process selecting at least 411 members of the eligible

population. MHP may use a 5 percent, 10 percent, 15 percent, or 20 percent oversample to replace invalid cases (e.g., a male selected for *Postpartum Care*).

Figure 2-1 shows that if 411 members are included in a measure, the margin of error is approximately ± 4.9 percentage points. Note that the data in this figure are based on the assumption that the size of the eligible population is greater than 2,000. The smaller the sample included in the measure, the larger the sampling error.

Figure 2-1—Relationship of Sample Size to Sample Error



As Figure 2-1 shows, sample error decreases as the sample size gets larger. Consequently, when sample sizes are very large and sampling errors are very small, almost any difference is statistically significant. This does not mean that all such differences are important. On the other hand, the difference between two measured rates may not be statistically significant but may, nevertheless, be important. The judgment of the reviewer is always a requisite for meaningful data interpretation.

Data Sources and Measure Audit Results

MHP-specific performance displayed in this report was based on data elements obtained from the Interactive Data Submission System (IDSS) files supplied by the MHPs. Prior to HSAG's receipt of the MHPs' IDSS files, all the MHPs were required by MDHHS to have their HEDIS MY 2022 results examined and verified through an NCQA HEDIS Compliance Audit.[2-1]

Through the audit process, each measure indicator rate reported by an MHP was assigned an NCQA-defined audit result. HEDIS MY 2022 measure indicator rates received one of seven predefined audit results: *Reportable (R)*, *Small Denominator (NA)*, *Biased Rate (BR), No Benefit (NB), Not Required (NQ), Un-Audited (UN)*, and *Not Reported (NR)*. The audit results are defined in Section 12.

Rates designated as *NA*, *BR*, *NB*, *NQ*, *UN*, or *NR* are not presented in this report. All measure indicator rates that are presented in this report have been verified as an unbiased estimate of the measure. Please see Section 11 for additional information on NCQA's Information System (IS) standards and the audit findings for the MHPs.

Calculation of Statewide Averages

For all measures, HSAG collected the audited results, numerator, denominator, rate, and eligible population elements reported in the files submitted by MHPs to calculate the MWA rate. Given that the MHPs varied in membership size, the MWA rate was calculated for most of the measures based on MHPs' eligible populations. Weighting the rates by the eligible population sizes ensured that a rate for an MHP with 125,000 members, for example, had a greater impact on the overall MWA rate than a rate for the MHP with only 10,000 members. For MHPs' rates reported as *NA*, the numerators, denominators, and eligible populations were included in the calculations of the MWA rate. MHP rates reported as *BR*, *NB*, *NQ*, *UN*, or *NR* were excluded from the MWA rate calculation. However, traditional unweighted statewide Medicaid average rates were calculated for some utilization-based measures to align with calculations from prior years' deliverables.

Evaluating Measure Results

National Benchmark Comparisons

Benchmark Data

HEDIS MY 2022 MHP and MWA rates were compared to the corresponding national HEDIS benchmarks, which are expressed in percentiles of national performance for different measures. For comparison, HSAG used the most recent data available from NCQA at the time of the publication of this

[2-1] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

report to evaluate the HEDIS MY 2022 rates: NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2021 MWA, which are referred to as "percentiles" throughout this report.

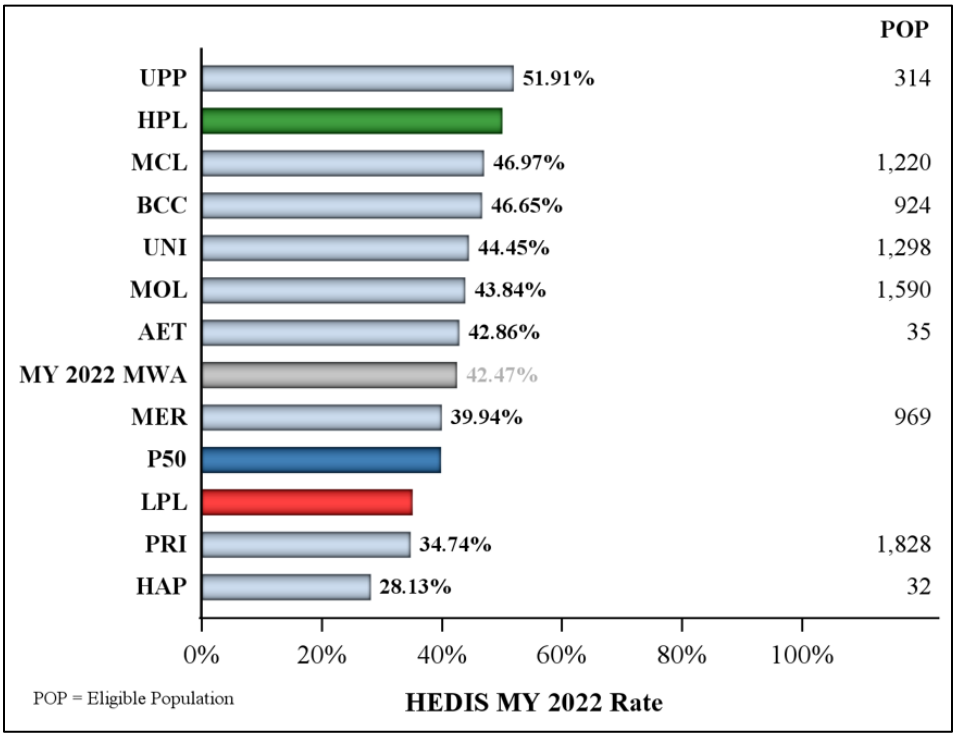
Additionally, benchmarking data (i.e., NCQA's Quality Compass and NCQA's Audit Means and Percentiles) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays.

Figure Interpretation

For each performance measure indicator presented in Sections 3 through 8 of this report, the horizontal bar graph figure positioned on the right side of the page presents each MHP's performance against the HEDIS MY 2022 MWA (i.e., the bar shaded gray); the HPL (i.e., the green shaded bar), representing the 90th percentile; the P50 bar (i.e., the blue shaded bar), representing the 50th percentile; and the LPL (i.e., the red shaded bar), representing the 25th percentile.

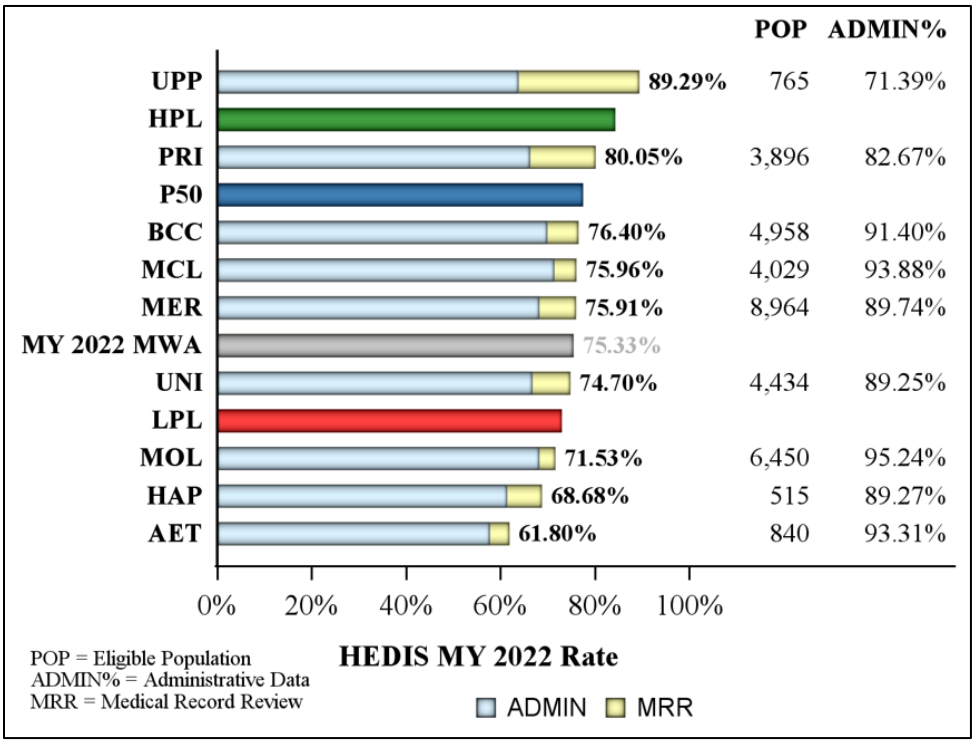
For measures for which lower rates indicate better performance, the 10th percentile (rather than the 90th percentile) and the 75th percentile (rather than the 25th percentile) are considered the HPL and LPL, respectively. An example of the horizontal bar graph figure for measure indicators reported administratively is shown below in Figure 2-2.

Figure 2-2—Sample Horizontal Bar Graph Figure for Administrative Measures



For performance measure rates that were reported using the hybrid method, the "ADMIN%" column presented with each horizontal bar graph figure displays the percentage of the rate derived from administrative data (e.g., claims data and supplemental data). The portion of the bar shaded yellow represents the proportion of the total measure rate attributed to medical record review, while the portion of the bar shaded light blue indicates the proportion of the measure rate that was derived using the administrative method. This percentage describes the level of claims/encounter data completeness of the MHP data for calculating a particular performance measure. A low administrative data percentage suggests that the MHP relied heavily on medical records to report the rate. Conversely, a high administrative data percentage indicates that the MHP's claims/encounter data were relatively complete for use in calculating the performance measure indicator rate. An administrative percentage of 100 percent indicates that the MHP did not report the measure indicator rate using the hybrid method. An example of the horizontal bar graph figure for measure indicators reported using the hybrid method is shown in Figure 2-3.

Figure 2-3—Sample Horizontal Bar Graph Figure for Hybrid Measures



Percentile Rankings and Star Ratings

In addition to illustrating MHP and statewide performance via side-by-side comparisons to national percentiles, benchmark comparisons are denoted within Appendix B of this report using the percentile ranking performance levels and star ratings defined below in Table 2-3.

Table 2-3—Percentile Ranking Performance Levels

Star Rating	Performance Level
★★★★★	At or above the 90th percentile
★★★★	At or above the 75th percentile but below the 90th percentile
★★★	At or above the 50th percentile but below the 75th percentile
★★	At or above the 25th percentile but below the 50th percentile
★	Below the 25th percentile
NA	NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
NB	NB indicates that the MHP did not offer the health benefit required by the measure.

Measures in the Health Plan Diversity and Utilization measure domains are designed to capture the frequency of services provided and characteristics of the populations served. Excluding the *Ambulatory Care—Total—ED Visits*, *Use of Opioids From Multiple Providers*, *Use of Opioids at High Dosage*, *Risk of Continued Opioid Use*, and *Plan All-Cause Readmissions* measures, higher or lower rates in these domains do not necessarily indicate better or worse performance. A lower rate for *Ambulatory Care—Total—ED Visits* may indicate a more favorable performance since lower rates of ED services may indicate better utilization of services. Further, measures under the Health Plan Diversity measure domain provide insight into how member race/ethnicity or language characteristics are compared to national distributions and are not suggestive of plan performance.

For the *Ambulatory Care—Total—ED Visits* and *Plan All-Cause Readmissions* measure indicators, HSAG inverted the star ratings to be consistently applied to these measures as with the other HEDIS measures. For example, the 10th percentile (a lower rate) was inverted to become the 90th percentile, indicating better performance.

Of note, MHP and statewide average rates were rounded to the second decimal place before performance levels were determined. As HSAG assigned star ratings, an em dash (—) was presented to indicate that the measure indicator was not required and not presented in previous years' HEDIS deliverables; or that a performance level was not presented in this report either because the measure did not have an applicable benchmark or a comparison to benchmarks was not appropriate.

Performance Trend Analysis

In addition to the star rating results, HSAG also compared HEDIS MY 2022 MWA and MHP rates to the corresponding HEDIS MY 2021 MWA rates. HSAG also evaluated the extent of changes observed in the rates between years. Year-over-year performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05 for MHP rate comparisons and a *p* value <0.01 for MWA rate comparisons. Note that statistical testing could not be performed on the utilization-based measures domain given that variances were not available in the IDSS files for HSAG to use for statistical testing. Further statistical testing was not performed on the health plan diversity measures because these measures are for information only.

In general, results from statistical significance testing provide information on whether a change in the rate may suggest improvement or decline in performance. Throughout the report, references to "significant" changes in performance are noted; these instances refer to statistically significant differences between performance from HEDIS MY 2021 MWA to HEDIS MY 2022. At the statewide level, if the number of MHPs reporting *NR* or *BR* differs vastly from year to year, the statewide performance may not represent all of the contracted MHPs, and any changes observed across years may need to take this factor into consideration. Nonetheless, changes (regardless of whether they are significant) could be related to the following factors independent of any effective interventions designed to improve the quality of care:

- Substantial changes in measure specifications. The "Measure Changes Between HEDIS MY 2021 MWA and HEDIS MY 2022" section below lists measures with specification changes made by NCQA.
- Substantial changes in membership composition within the MHP.

Table and Figure Interpretation

Within Sections 3 through 8 and Appendix B of this report, performance measure indicator rates and results of significance testing between HEDIS MY 2021 MWA and HEDIS MY 2022 are presented in tabular format. HEDIS MY 2022 rates shaded green with one cross ($^{+}$) indicate a significant improvement in performance from the previous year. HEDIS MY 2022 rates shaded red with two crosses ($^{++}$) indicate a significant decline in performance from the previous year. The colors used are provided below for reference:

+ *Indicates that the HEDIS MY 2022 MWA demonstrated a significant improvement from the HEDIS MY 2021 MWA.*

++ *Indicates that the HEDIS MY 2022 MWA demonstrated a significant decline from the HEDIS MY 2021 MWA.*

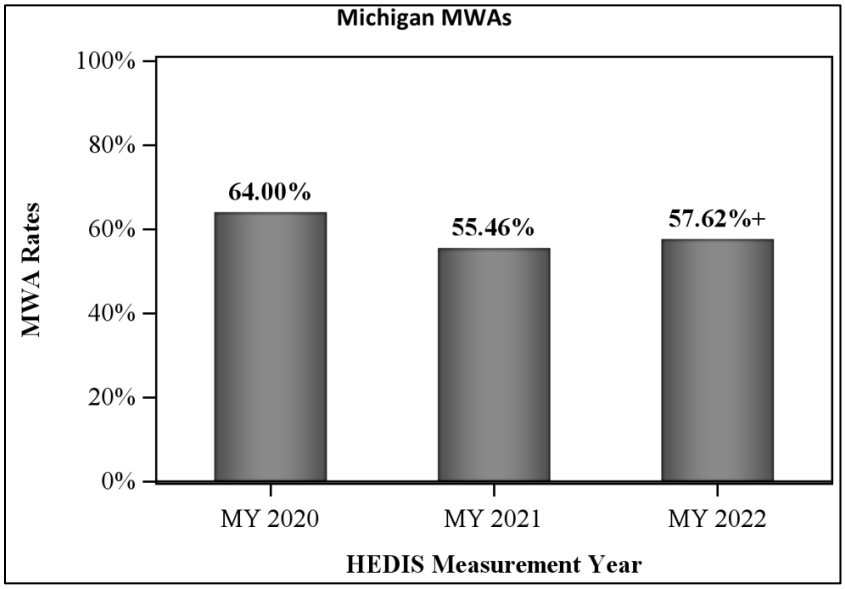
Additionally, benchmark comparisons are denoted within Sections 3 through 8. Performance levels are represented using the following percentile rankings:

Table 2-4—Percentile Ranking Performance Levels

Percentile Ranking and Shading	Performance Level
≥90th	At or above the 90th percentile
≥75th and ≤89th	At or above the 75th percentile but below the 90th percentile
≥50th and ≤74th	At or above the 50th percentile but below the 75th percentile
≥25th and ≤49th	At or above the 25th percentile but below the 50th percentile
<25th	Below the 25th percentile

For each performance measure indicator presented in Sections 3 through 8 of this report, the vertical bar graph figure positioned on the left side of the page presents the HEDIS MY 2020, HEDIS MY 2021 MWA, and HEDIS MY 2022 MWAs with significance testing performed between the HEDIS MY 2021 MWA and HEDIS MY 2022 MWAs. Within these figures, HEDIS MY 2022 rates with one cross ($^{+}$) indicate a significant improvement in performance from HEDIS MY 2021 MWA. HEDIS MY 2022 rates with two crosses ($^{++}$) indicate a significant decline in performance from HEDIS MY 2021 MWA. An example of the vertical bar graph figure for measure indicators reported is included in Figure 2-4.

Figure 2-4—Sample Vertical Bar Graph Figure Showing Significant Improvement



Interpreting Results Presented in This Report

HEDIS results can differ among MHPs and even across measures for the same MHP.

The following questions should be asked when examining these data:

How accurate are the results?

All Michigan MHPs are required by MDHHS to have their HEDIS results confirmed through an NCQA HEDIS Compliance Audit. As a result, any rate included in this report has been verified as an unbiased estimate of the measure. NCQA's HEDIS protocol is designed so that the hybrid method produces results with a sampling error of ± 5 percent at a 95 percent confidence level.

To show how sampling error affects the accuracy of results, an example was provided in the "Data Collection Methods" section above. When an MHP uses the hybrid method to derive a *Postpartum Care* rate of 52 percent, the true rate is actually within ± 5 percentage points of this rate, due to sampling error. For a 95 percent confidence level, the rate would be between 47 percent and 57 percent. If the target is a rate of 55 percent, it cannot be said with certainty whether the true rate between 47 percent and 57 percent meets or does not meet the target level.

To prevent such ambiguity, this report uses a standardized methodology that requires the reported rate to be at or above the threshold level to be considered as meeting the target. Michigan MHPs are advised to understand and consider the issue of sampling error when evaluating HEDIS results.

How do Michigan Medicaid rates compare to national percentiles?

For each measure, an MHP ranking presents the reported rate in order from highest to lowest, with bars representing the established HPL, LPL, and the national HEDIS MY 2021 MWA Medicaid 50th percentile. In addition, the HEDIS MY 2020, MY 2021, and MY 2022 MWA rates are presented for comparison.

Michigan MHPs with reported rates above the 90th percentile (HPL) rank in the top 10 percent of all MHPs nationally. Similarly, MHPs reporting rates below the 25th percentile (LPL) rank in the bottom 25 percent nationally for that measure.

How are Michigan MHPs performing overall?

For each domain of care, a performance profile analysis compares the MY 2022 MWA for each rate with the MY 2020 and MY 2021 MWA and the 50th percentile.

Measure Changes Between HEDIS MY 2021 and HEDIS MY 2022

The following is a list of measures with technical specification changes that NCQA announced for HEDIS MY 2022.[2-2] These changes may have an effect on the HEDIS MY 2022 rates that are presented in this report.

Appropriate Testing for Pharyngitis (CWP)

- Added step 8 to the event/diagnosis criteria. This step was inadvertently removed for MY 2021.

Prenatal and Postpartum Care (PPC)

- Removed the definition of "last enrollment segment" and clarified continuous enrollment requirements for steps 1 and 2 of *Timeliness of Prenatal Care* numerator.

Ambulatory Care (AMB)

- Updated the "Member Months" definition in Calculations to indicate that IDSS produces member years data for all product lines.

Inpatient Utilization—General Hospital/Acute Care (IPU)

- Updated the "Member Months" definition in Calculations to indicate that IDSS produces member years data for all product lines.

[2-2] National Committee for Quality Assurance. *HEDIS® MY 2022, Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA Publication, 2021.

3. Child & Adolescent Care

Introduction

The Child & Adolescent Care domain encompasses the following HEDIS measures:

- *Childhood Immunization Status—Combinations 3, 7, and 10*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*
- *Lead Screening in Children*
- *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years, Ages 12 to 17 Years, Ages 18 to 21 Years,* and *Total*
- *Immunizations for Adolescents—Combinations 1 and 2*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 3-1 presents the Michigan MWA performance for the measure indicators under the Child & Adolescent Care domain. The table lists the HEDIS MY 2022 MWA rates and performance levels, a comparison of the HEDIS MY 2021 MWA to the HEDIS MY 2022 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2021 to HEDIS MY 2022.

Table 3-1—HEDIS MY 2022 MWA Performance Levels and Trend Results for Child & Adolescent Care

Measure	HEDIS MY 2022 MWA and Performance Level[1]	HEDIS MY 2021 MWA–HEDIS MY 2022 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2022	Number of MHPs With Statistically Significant Decline in HEDIS MY 2022
Childhood Immunization Status				
Combination 3	57.62%	+2.16+	2	0
Combination 7	49.59%	+2.76+	2	0

Measure	HEDIS MY 2022 MWA and Performance Level[1]	HEDIS MY 2021 MWA–HEDIS MY 2022 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2022	Number of MHPs With Statistically Significant Decline in HEDIS MY 2022
Combination 10	25.29%	**-1.93^{++}**	0	2
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	60.06%	**+1.22^{+}**	6	2
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.86%	-0.13	4	2
Lead Screening in Children				
Lead Screening in Children	54.78%	+0.09	1	1
Child and Adolescent Well-Care Visits				
Ages 3 to 11 Years	59.20%	**+1.07^{+}**	3	1
Ages 12 to 17 Years	50.38%	**+0.45^{+}**	2	1
Ages 18 to 21 Years	28.31%	**-0.70^{++}**	0	3
Total	50.89%	**+0.40^{+}**	3	2
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	76.96%	+0.32	0	0
Combination 2 (Meningococcal, Tdap, HPV)	29.35%	**-3.50^{++}**	0	2
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	42.47%	**+2.18^{+}**	3	0
Continuation and Maintenance Phase	47.93%	-3.31	0	0

[1] HEDIS MY 2022 performance levels were based on comparisons of the HEDIS MY 2022 MWA rates to national Medicaid Quality Compass HEDIS MY 2021 MWA benchmarks. HEDIS MY 2022 performance levels represent the following percentile comparisons:

<25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] HEDIS MY 2021 MWA to HEDIS MY 2022 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading^{+} *Indicates that the HEDIS MY 2022 MWA demonstrated a significant improvement from the HEDIS MY 2021 MWA.*

Red Shading^{++} *Indicates that the HEDIS MY 2022 MWA demonstrated a significant decline from the HEDIS MY 2021 MWA.*

Table 3-1 shows that for the Child & Adolescent Care domain, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*; *Child and Adolescent Well-Care Visits—Ages 3 to 11 Years* and *Total*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicators were an area of strength. All measure indicators ranked at or above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2021 MWA. Priority, Upper Peninsula, Blue Cross, Molina, and Meridian ranked above the 50th percentile for the most measure indicators within the Child & Adolescent Care domain. Upper Peninsula and Blue Cross ranked above the HPL for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator, and Upper Peninsula ranked above the HPL for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator.

The MWA demonstrated a significant decline for *Childhood Immunization Status—Combination 10*; *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years*; and *Immunizations for Adolescents—Combination 2* indicators. The MWA for the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* indicators had an MWA decrease of nearly 2 percentage points and over 3 percentage points, respectively, from HEDIS MY 2021, and ranked below the 25th percentile.

MDHHS should continue to monitor the MHPs' performance on the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measure indicators to ensure that the MHPs' performance does not continue to decline, while working with the MHPs and providers to target improving child and adolescent vaccination rates. Immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.[3-1] The identified declines in routine pediatric vaccine ordering and doses administered might indicate that children in the United States and their communities face increased risks for outbreaks of vaccine-preventable diseases. Reminding parents of the vital need to protect their children against serious vaccine-preventable diseases, even as COVID-19 continues to be a health concern, is critical. Children who are not protected by vaccines will be more vulnerable to communicable and preventable diseases such as measles. In response, continued coordinated efforts between healthcare providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[3-2]

Additionally, MDHHS should work with the MHPs and providers to identify potential root causes for the significant decline for the *Child and Adolescent Well-Care Visits—Ages 18 to 21 Years* measure indicator. Assessing physical, emotional, and social development is important at every stage of life, particularly with children and adolescents. Well-care visits provide an opportunity for providers to

[3-1] National Committee for Quality Assurance. Childhood Immunization Status. Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Aug 31, 2023.

[3-2] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Aug 31, 2023.

influence health and development, and they are a critical opportunity for screening and counseling.[3-3] Well-care visits between the ages of 18 and 21 years can also assist in the successful transition from pediatric to adult-oriented healthcare to ensure ongoing medical treatment, as needed. The goal of a planned healthcare transition is to maximize lifelong functioning and well-being for all youth, including those who have SHCN and those who do not. This process includes ensuring that high-quality, developmentally appropriate healthcare services are available and uninterrupted as the person moves from adolescence to adulthood. A well-timed transition from child- to adult-oriented healthcare is specific to each person and ideally occurs between the ages of 18 and 21 years. Coordination of patient, family, and provider responsibilities enables youth to optimize their ability to assume adult roles and activities. [3-4]

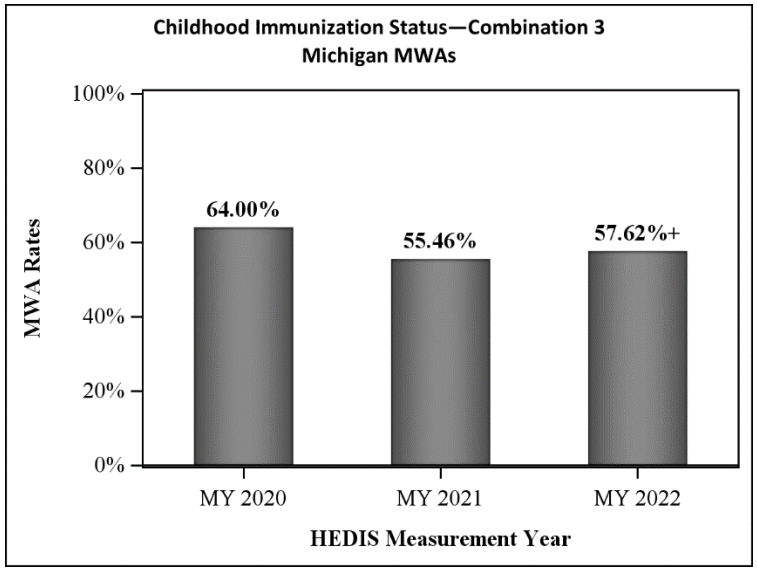
[3-3] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Aug 31, 2023.

[3-4] American Academy of Pediatrics. Supporting the Health Care Transition from Adolescence to Adulthood in the Medical Home. Available at: https://publications.aap.org/pediatrics/article/128/1/182/30310/Supporting-the-Health-Care-Transition-From?autologincheck=redirected Accessed on: August 31, 2023.

Measure-Specific Findings

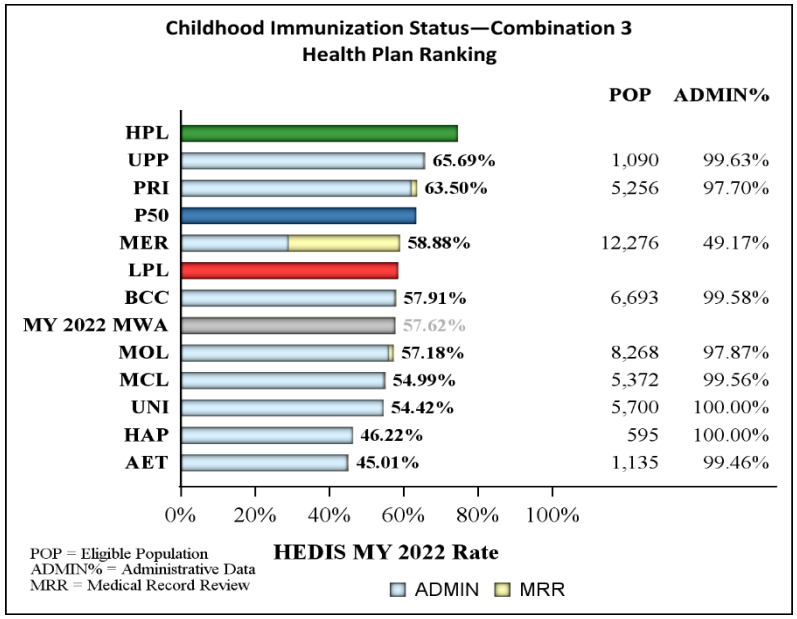
Childhood Immunization Status—Combination 3

Childhood Immunization Status—Combination 3 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four diphtheria, tetanus, and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), three haemophilus influenza type B (HiB), three hepatitis B (HepB), one chicken pox (VZV), and four pneumococcal conjugate (PCV).



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

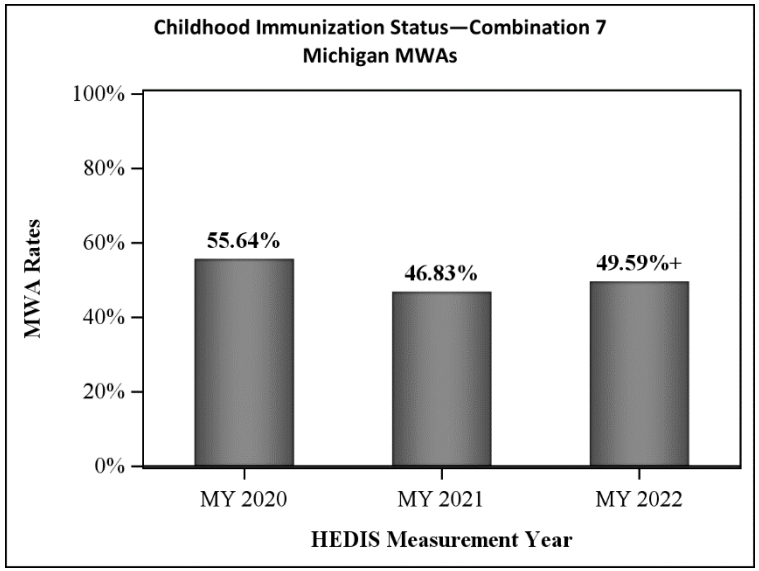
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Two MHPs ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. Six MHPs and the MWA fell below the LPL. MHP performance varied by over 20 percentage points.

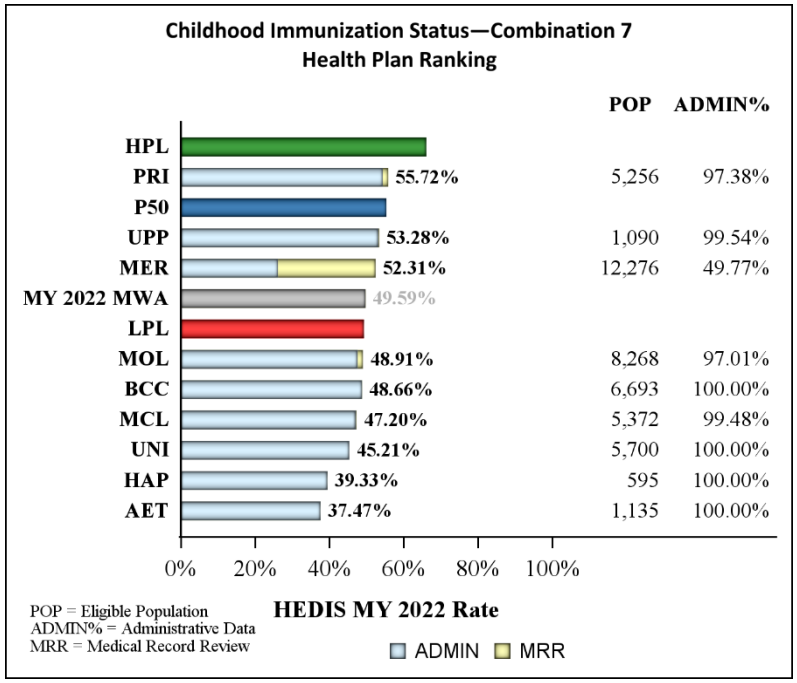
Childhood Immunization Status—Combination 7

Childhood Immunization Status—Combination 7 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, and two or three rotavirus (RV).



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

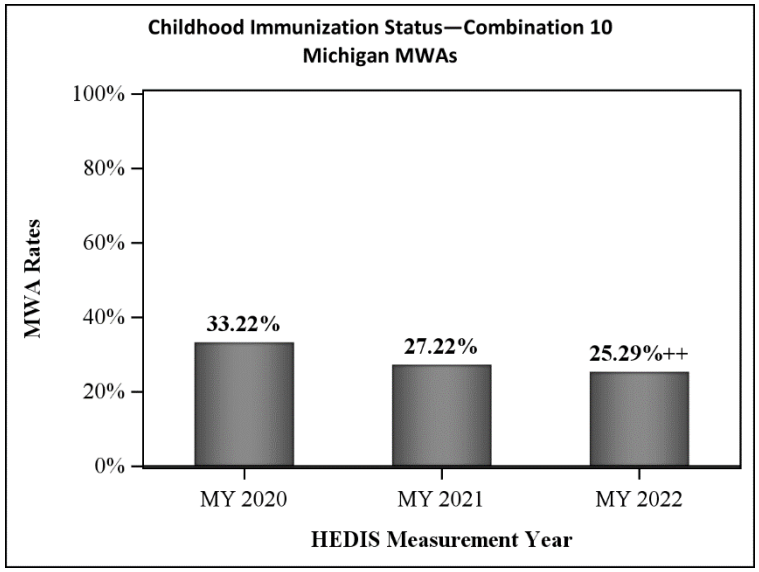
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



One MHP ranked above the 50th percentile but fell below the HPL. Two MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Six MHPs fell below the LPL. MHP performance varied by over 18 percentage points.

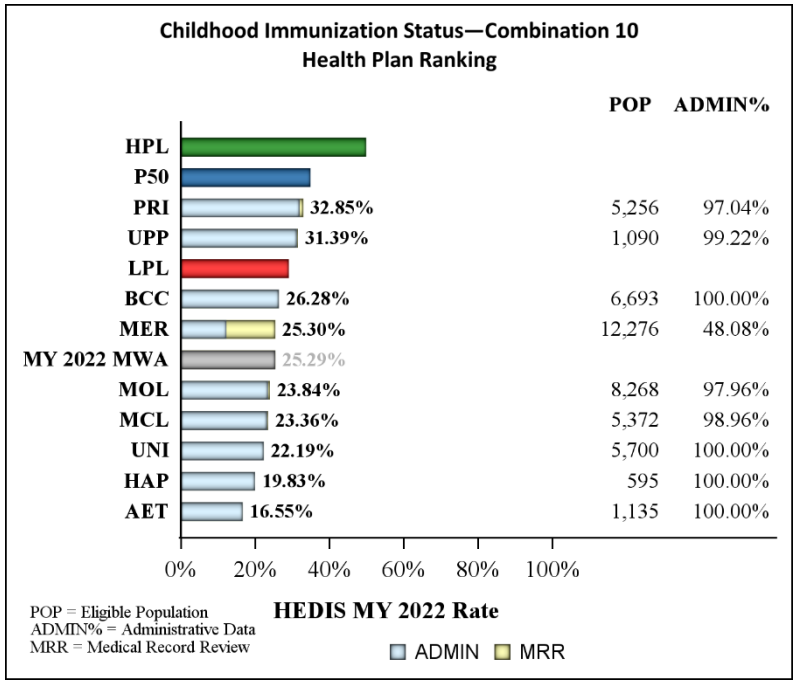
Childhood Immunization Status—Combination 10

Childhood Immunization Status—Combination 10 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, two or three RV, and two influenza.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

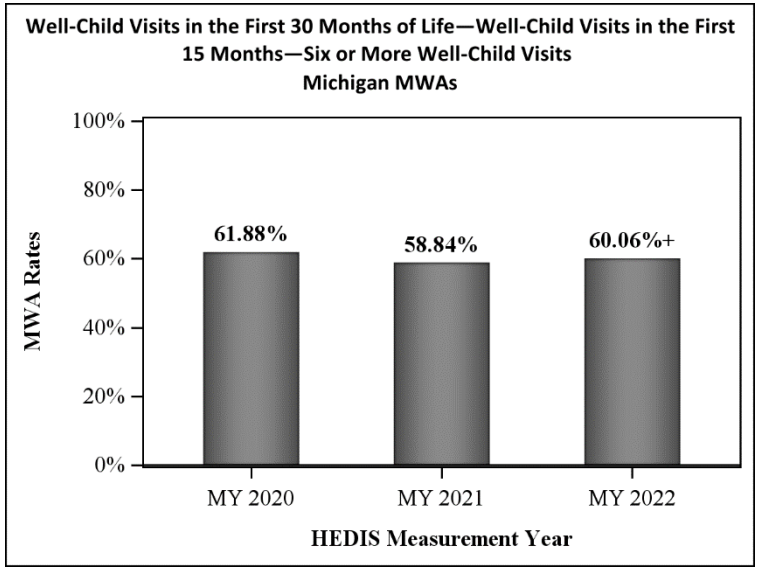
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



Two MHPs ranked above the LPL but fell below the 50th percentile and HPL. Seven MHPs and the MWA fell below the LPL. MHP performance varied by over 16 percentage points.

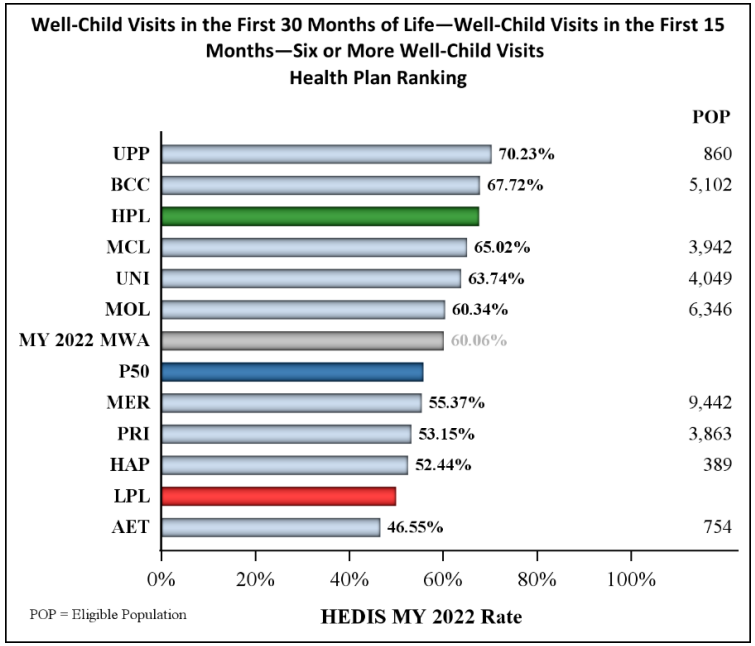
Well-Child Visits in the First 30 Months of Life—Well Child Visits in the First 15 Months—Six or More Well-Child Visits

Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits assesses the percentage of members who turned 15 months old during the MY who received six or more well-child visits with a PCP during their first 15 months of life.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

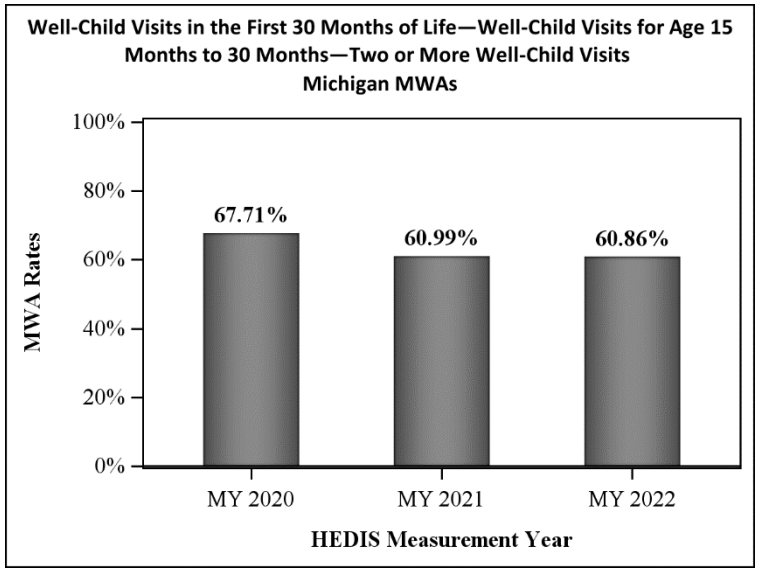
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



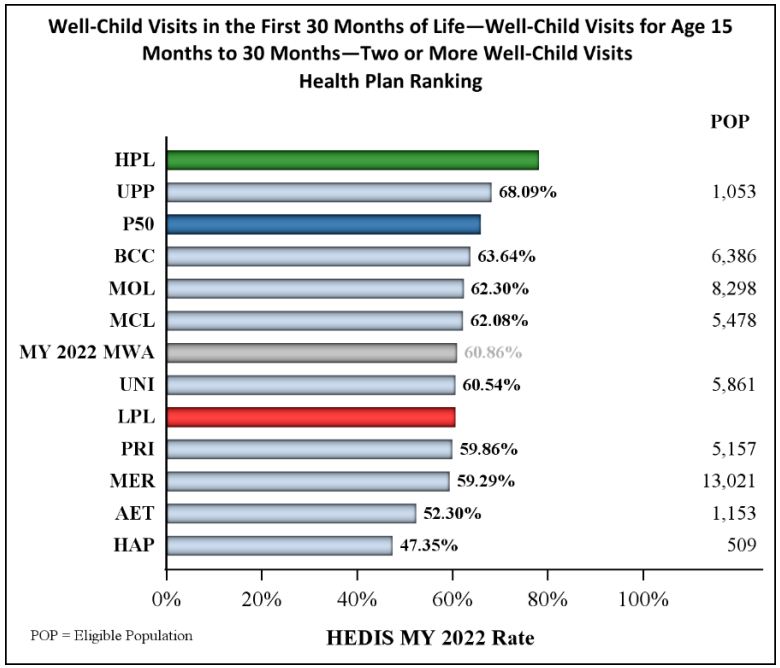
Two MHPs ranked above the HPL. Three MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Three MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 23 percentage points.

Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits

Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits assesses the percentage of members who turned 30 months old during the MY who received two or more well-child visits with a PCP during their first 15 months of life.



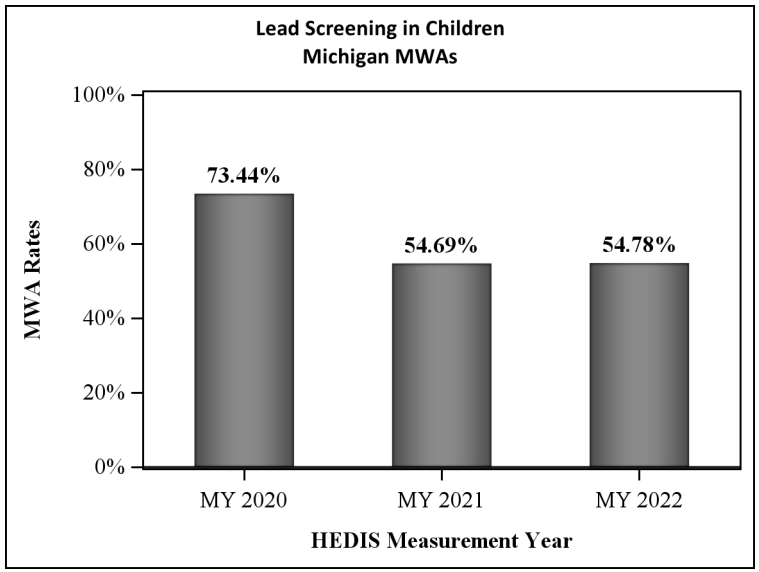
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



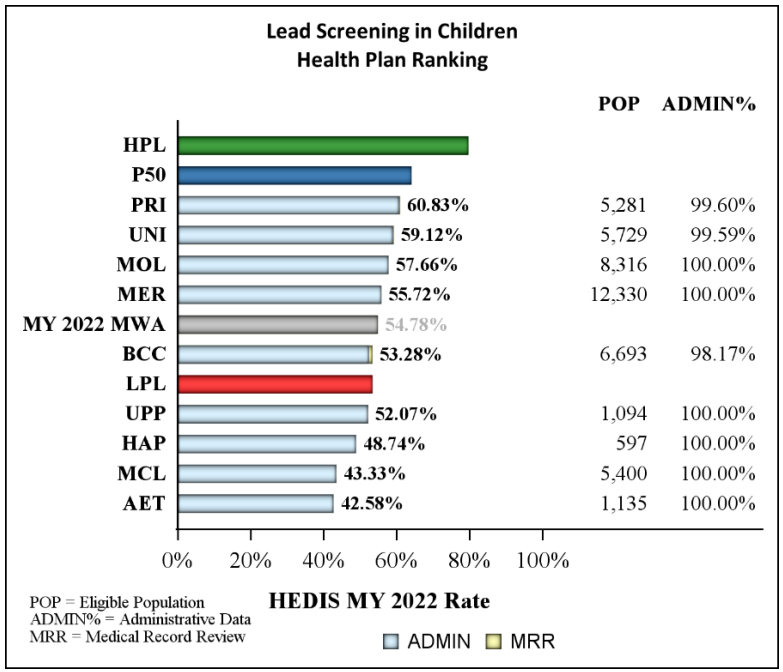
One MHP ranked above the 50th percentile but fell below the HPL. Four MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Four MHPs fell below the LPL. MHP performance varied by over 20 percentage points.

Lead Screening in Children

Lead Screening in Children assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.



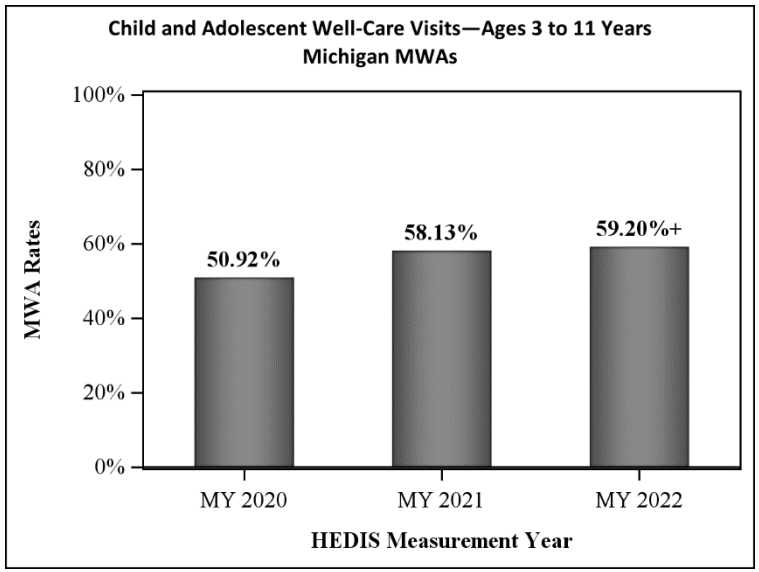
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



Five MHPs and the MWA ranked above the LPL but fell below the HPL and 50th percentile. Four MHPs fell below the LPL. MHP performance varied by over 18 percentage points.

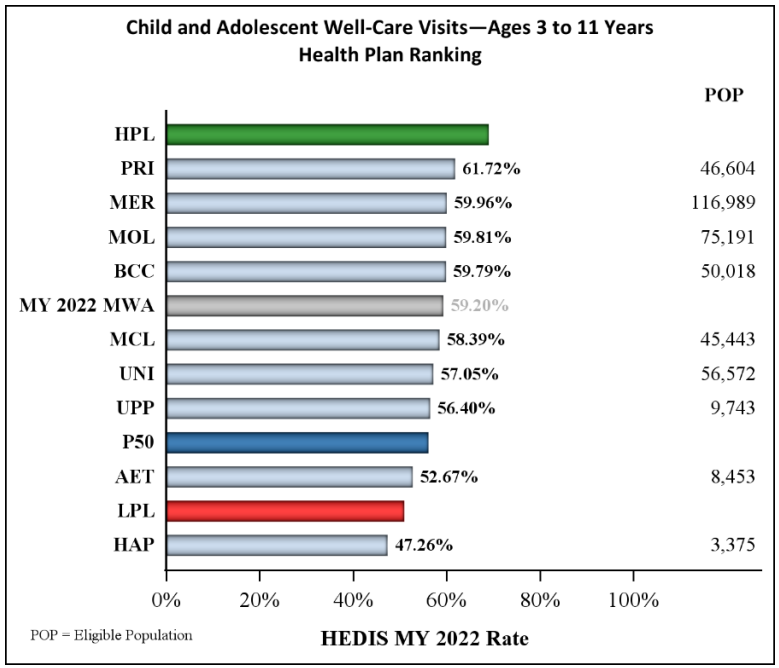
Child and Adolescent Well-Care Visits—Ages 3 to 11 Years

Child and Adolescent Well-Care Visits—Ages 3 to 11 Years assesses the percentage of members who were 3 to 11 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

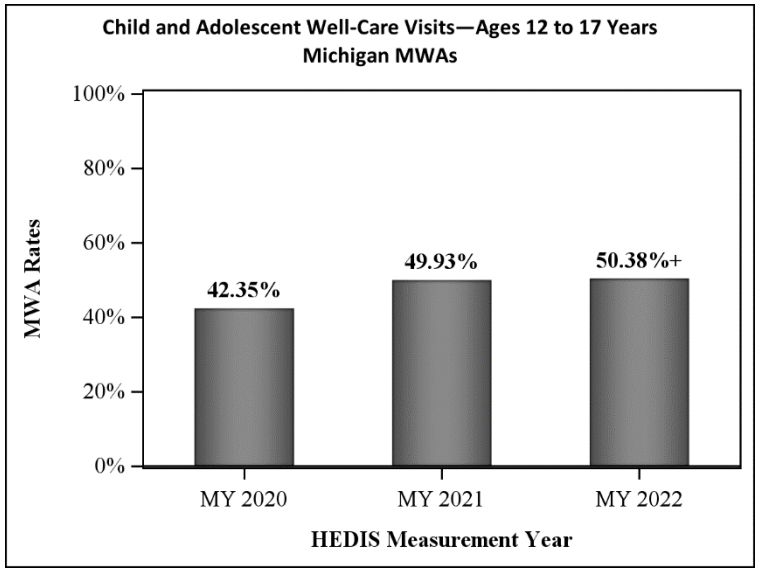
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 14 percentage points.

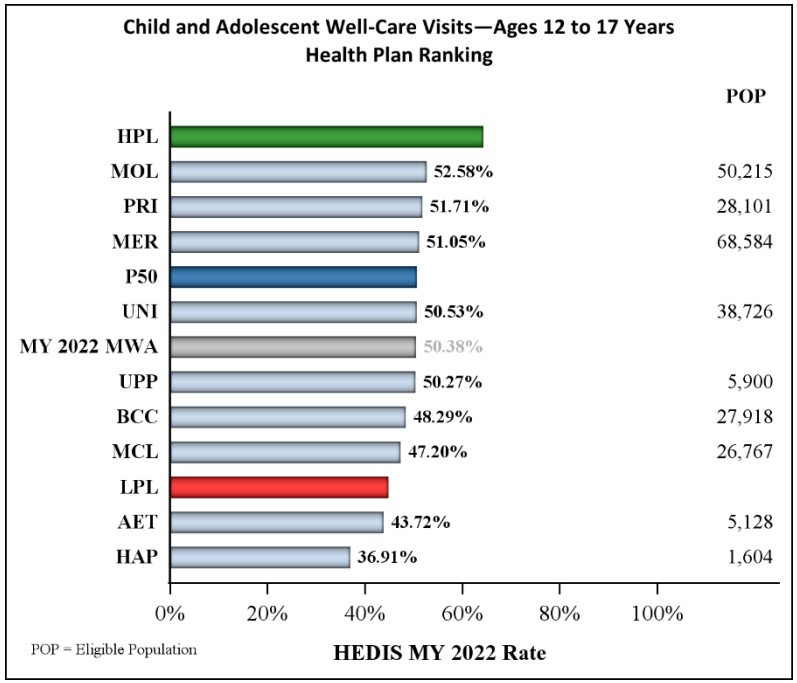
Child and Adolescent Well-Care Visits—Ages 12 to 17 Years

Child and Adolescent Well-Care Visits—Ages 12 to 17 Years assesses the percentage of members who were 12 to 17 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

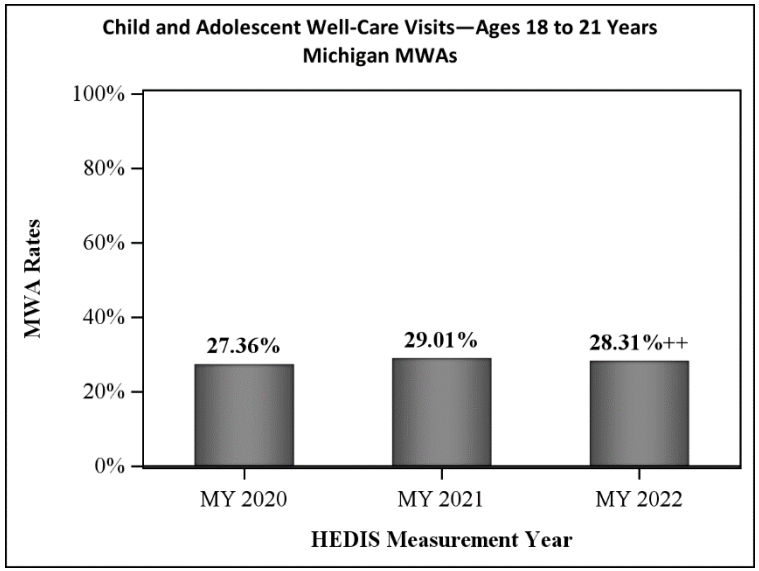
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Three MHPs ranked above the 50th percentile but fell below the HPL. Four MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 15 percentage points.

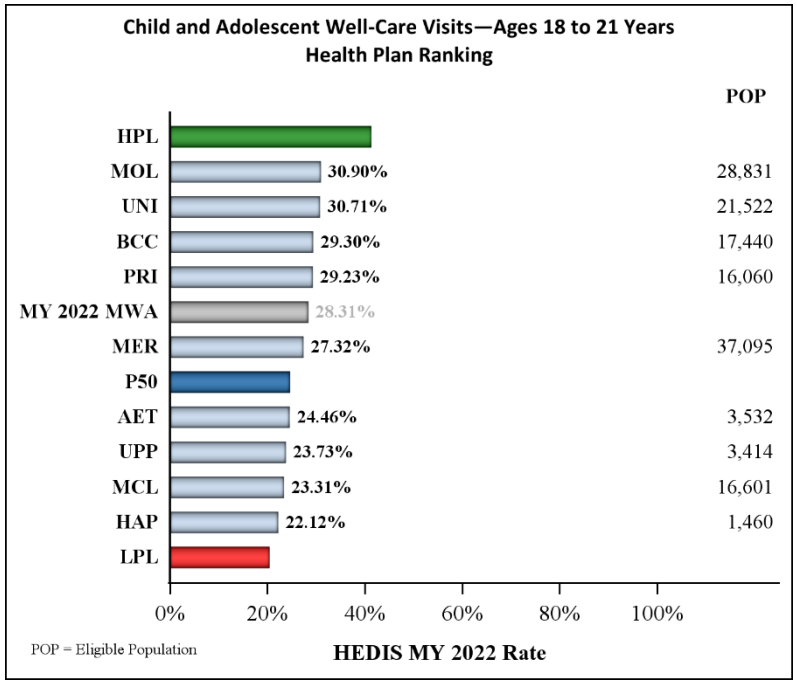
Child and Adolescent Well-Care Visits—Ages 18 to 21 Years

Child and Adolescent Well-Care Visits—Ages 18 to 21 Years assesses the percentage of members who were 18 to 21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

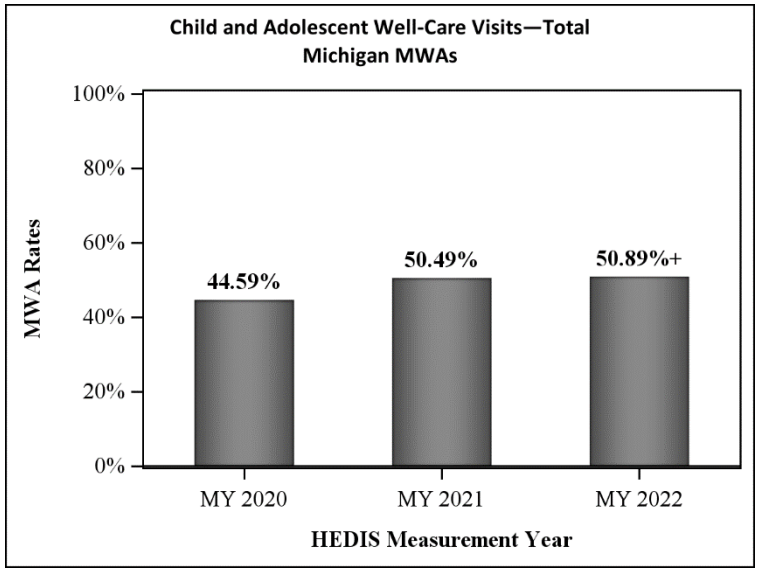
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Four MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 8 percentage points.

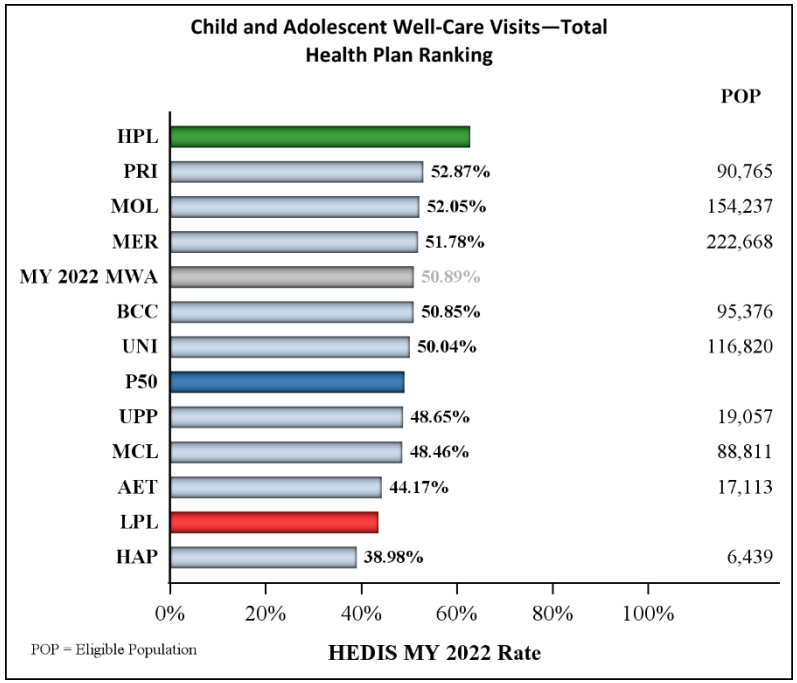
Child and Adolescent Well-Care Visits—Total

Child and Adolescent Well-Care Visits—Total assesses the percentage of members who were 3 to 21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

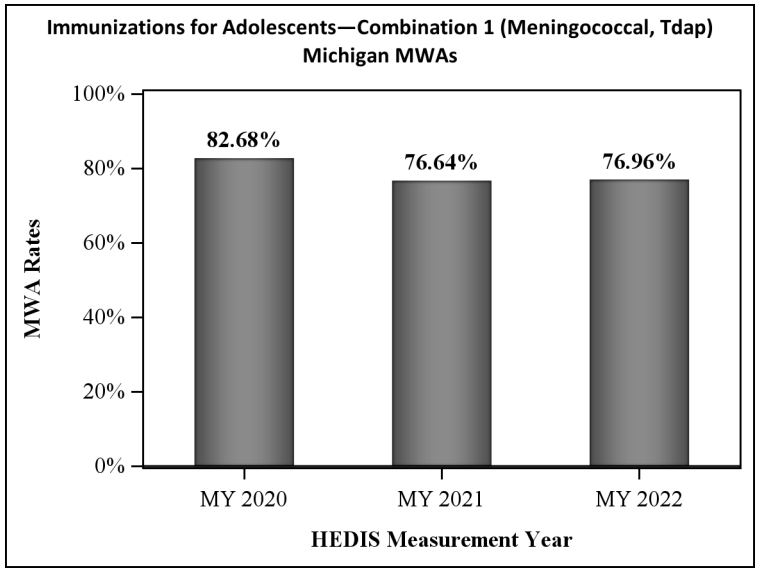
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



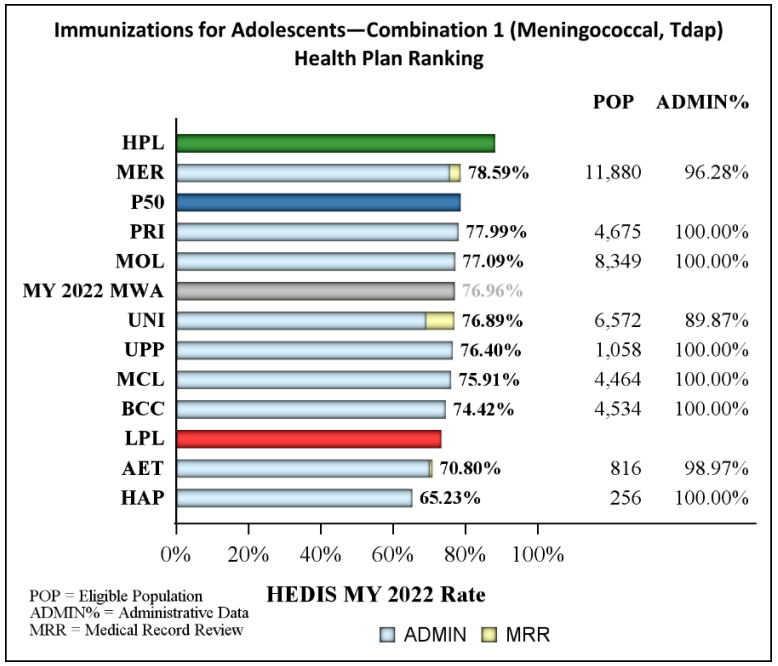
Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Three MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 13 percentage points.

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)

Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) assesses the percentage of adolescents 13 years of age who had the following by their 13th birthday: one dose of meningococcal vaccine and one Tdap vaccine.



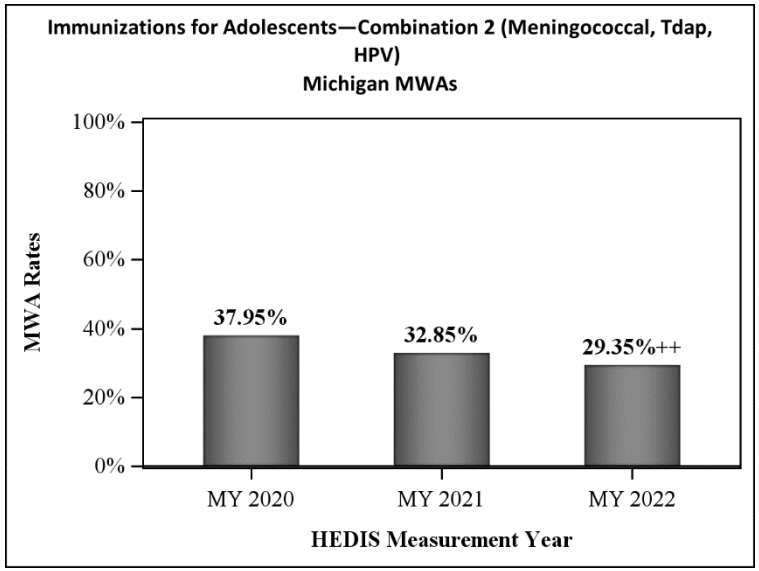
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



One MHP ranked above the 50th percentile but fell below the HPL. Six MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 13 percentage points.

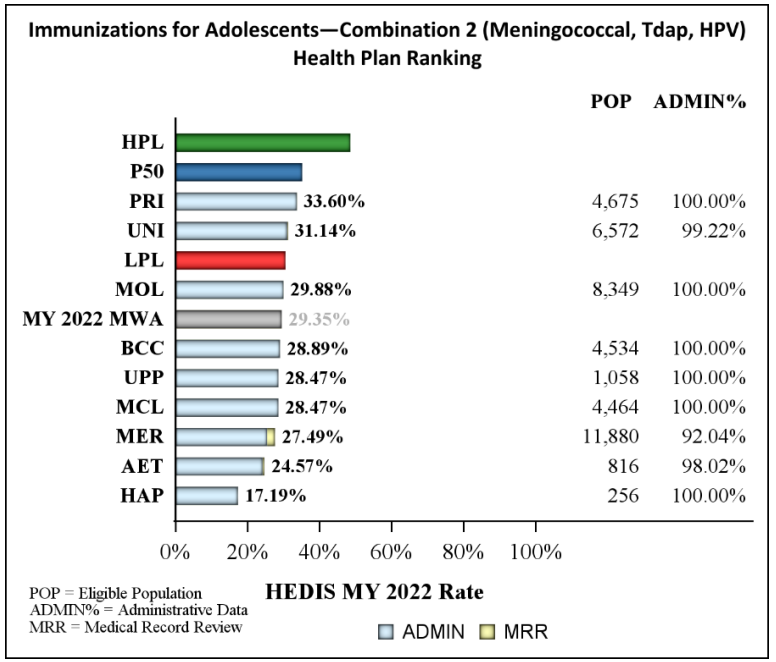
Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)

Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV) assesses the percentage of adolescents 13 years of age who had the following by their 13th birthday: one dose of meningococcal vaccine, one Tdap vaccine, and two HPV.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

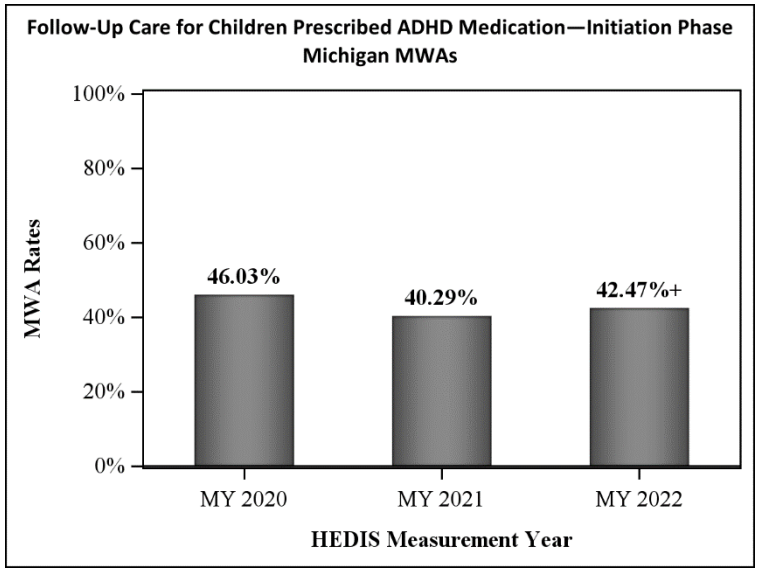
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



Two MHPs ranked above the LPL but fell below the HPL and the 50th percentile. Seven MHPs and the MWA fell below the LPL. MHP performance varied by over 16 percentage points.

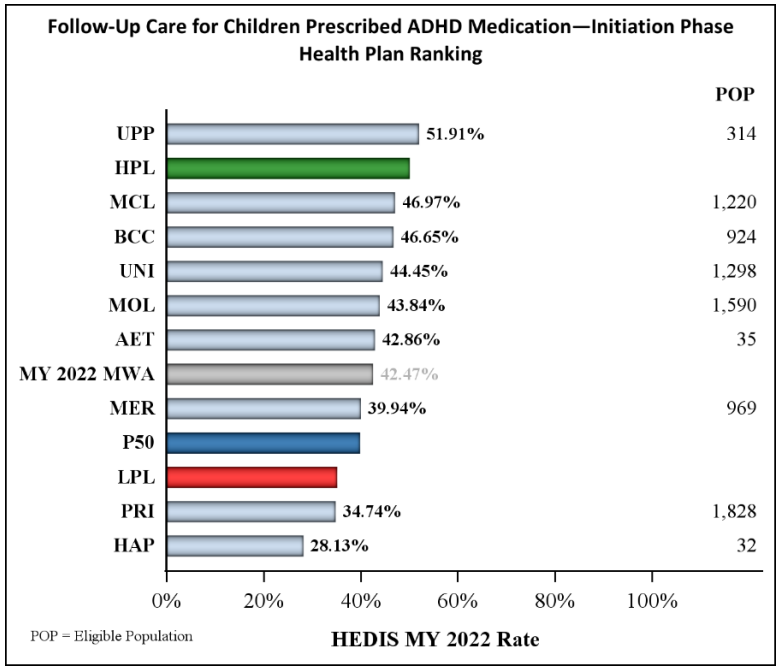
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase

Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase assesses the percentage of children 6 to 12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

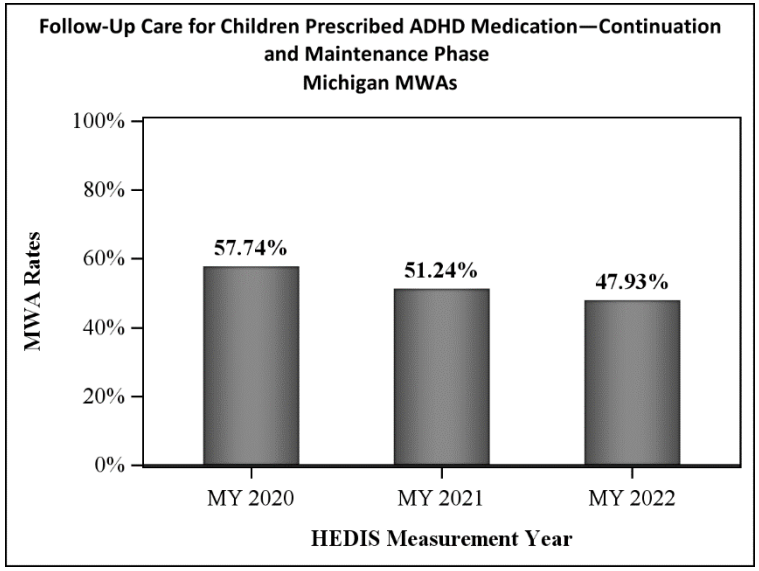
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



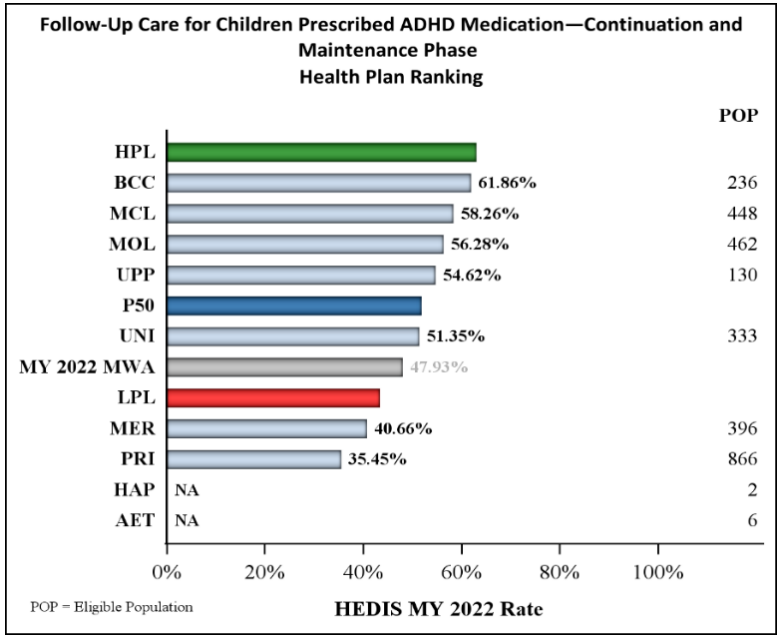
One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs fell below the LPL. MHP performance varied by over 23 percentage points.

Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase

Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase assesses the percentage of children 6 to 12 years with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.



The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Four MHPs ranked above the 50th percentile but fell below the HPL. One MHP and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 26 percentage points.

4. Women—Adult Care

Introduction

The Women—Adult Care domain encompasses the following HEDIS measures:

- *Chlamydia Screening in Women—Ages 16 to 20 Years, Ages 21 to 24 Years,* and *Total*
- *Cervical Cancer Screening*
- *Breast Cancer Screening*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 4-1 presents the Michigan MWA performance for the measure indicators under the Women—Adult Care domain. The table lists the HEDIS MY 2022 MWA rates and performance levels, a comparison of the HEDIS MY 2021 MWA to the HEDIS MY 2022 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2021 MWA to HEDIS MY 2022 MWA.

Table 4-1—HEDIS MY 2022 MWA Performance Levels and Trend Results for Women—Adult Care

Measure	HEDIS MY 2022 MWA and Performance Level[1]	HEDIS MY 2021 MWA–HEDIS MY 2022 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2022	Number of MHPs With Statistically Significant Decline in HEDIS MY 2022
Chlamydia Screening in Women				
Ages 16 to 20 Years	59.35%	+1.26+	3	1
Ages 21 to 24 Years	66.34%	+2.19+	4	0
Total	62.76%	+1.76+	4	1
Cervical Cancer Screening				
Cervical Cancer Screening	59.16%	+1.15+	1	0
Breast Cancer Screening				
Breast Cancer Screening	53.68%	+1.38+	3	1

[1] HEDIS MY 2022 performance levels were based on comparisons of the HEDIS MY 2022 MWA rates to national Medicaid Quality Compass HEDIS MY 2021 MWA benchmarks. HEDIS MY 2022 performance levels represent the following percentile comparisons:

<25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] HEDIS MY 2021 MWA to HEDIS MY 2022 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading[+] *Indicates that the HEDIS MY 2022 MWA demonstrated a significant improvement from the HEDIS MY 2021 MWA.*

Red Shading[++] *Indicates that the HEDIS MY 2022 MWA demonstrated a significant decline from the HEDIS MY 2021 MWA.*

Table 4-1 shows that for the Women—Adult Care domain, the *Chlamydia Screening in Women—Ages 16 to 20 Years*, *Ages 21 to 24 Years*, and *Total; Cervical Cancer Screening*; and *Breast Cancer Screening* measure indicators were all an area of strength. All measure indicators ranked at or above the 50th percentile, with the *Chlamydia Screening in Women—Total* measure indicator ranking at or above the 75th percentile. Additionally, all measure indicators demonstrated significant improvement from the HEDIS MY 2021 MWA. Blue Cross, Meridian, Molina, Priority, and UnitedHealthcare ranked above the 50th percentile for the most measure indicators within the Women—Adult Care domain. In addition, Meridian ranked above the HPL for the *Chlamydia Screening in Women—21 to 24 Years* measure indicator.

While none of the measure indicators in the Women—Adult Care domain demonstrated a significant decline in the MWA from HEDIS MY 2021, one MHP demonstrated a statistically significant decline in MY 2022 for the *Chlamydia Screening in Women—Ages 16 to 20 Years* and *Total,* and *Breast Cancer Screening* measure indicators. MDHHS should continue to monitor the MHPs' performance related to these measure indicators within the Women—Adult Care domain to maintain and further improve performance. It has been widely researched and validated that screening can improve outcomes and early detection, reduce the risk of dying, and lead to a greater range of treatment options and lower healthcare costs.[4-1] A reduction in patient structural barriers (such as office hours, scheduling assistance, translation services, and decreasing the number of clinic visits) could potentially further increase access to and utilization of needed screenings.[4-2]

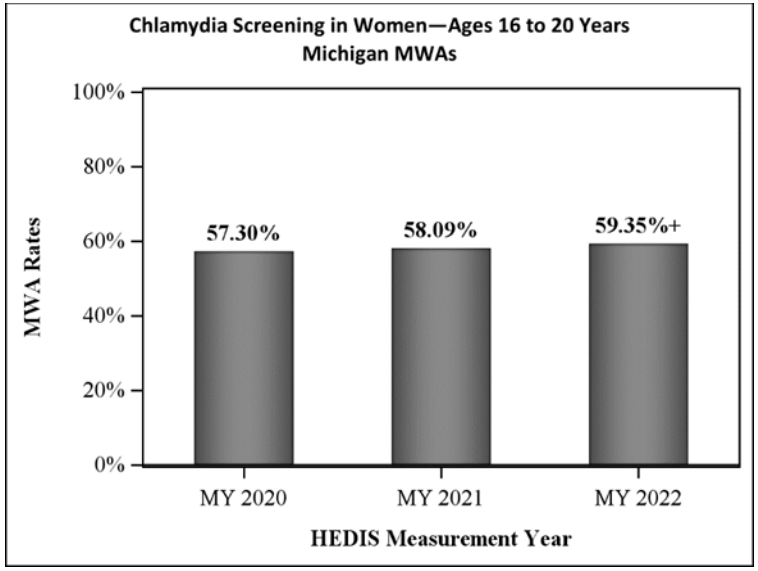
4-1 National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Aug 31, 2023.

4-2 Centers for Disease Control and Prevention. Reducing Structural Barriers Planning Guide. Available at: https://www.cdc.gov/screenoutcancer/ebi-planning-guides/reducing-structural-barriers-planning-guide.htm Accessed on: Aug 31, 2023.

Measure-Specific Findings

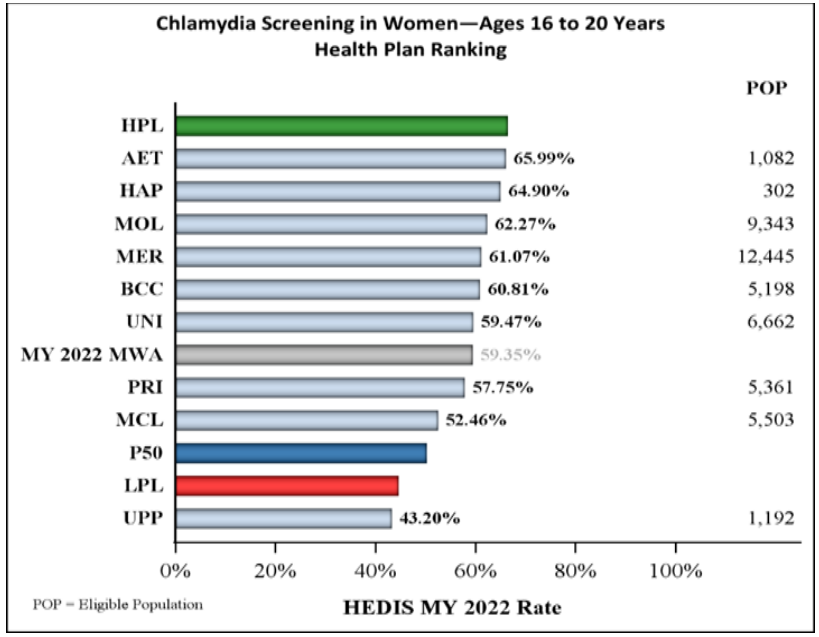
Chlamydia Screening in Women—Ages 16 to 20 Years

Chlamydia Screening in Women—Ages 16 to 20 Years assesses the percentage of women 16 to 20 years of age who were identified as sexually active and had at least one test for chlamydia during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

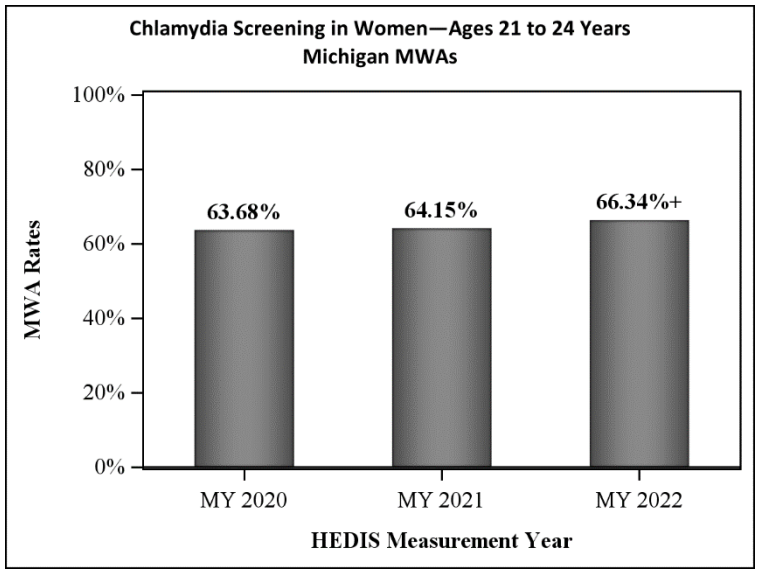
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 22 percentage points.

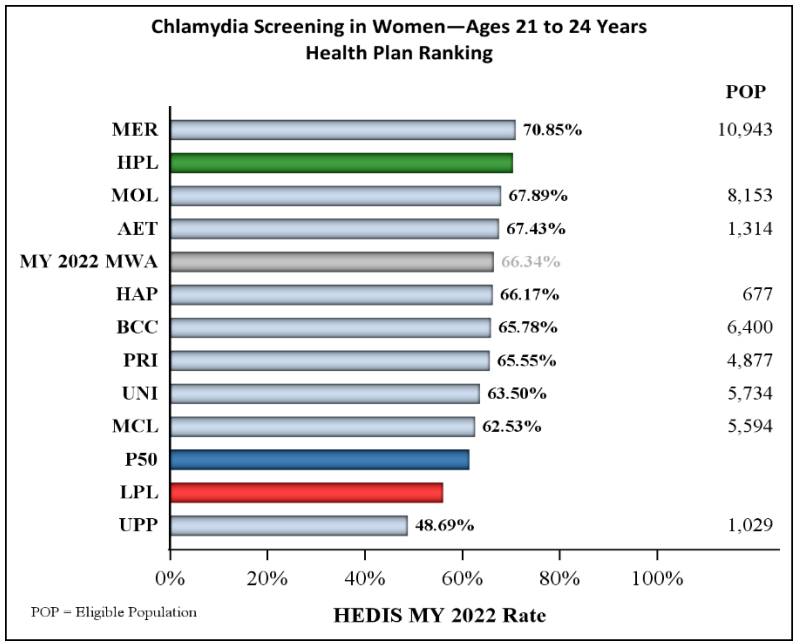
Chlamydia Screening in Women—Ages 21 to 24 Years

Chlamydia Screening in Women—21 to 24 Years assesses the percentage of women 21 to 24 years of age who were identified as sexually active and had at least one test for chlamydia during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

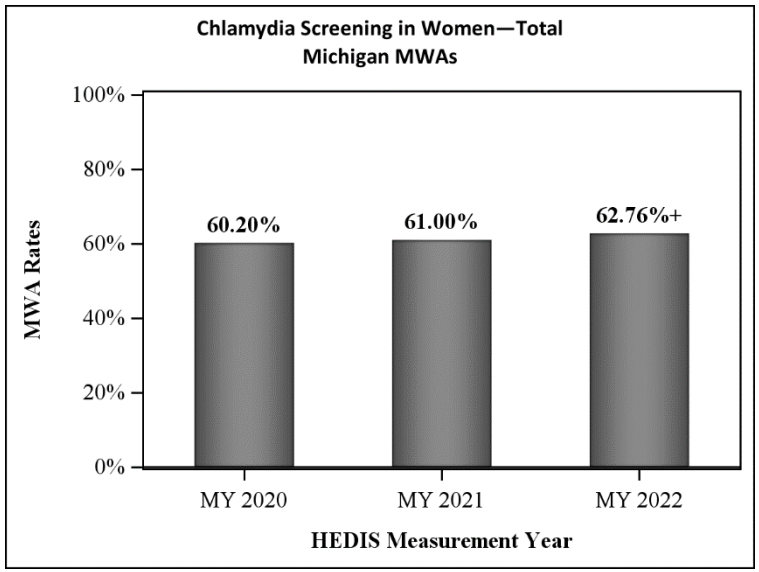
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



One MHP ranked above the HPL. Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 22 percentage points.

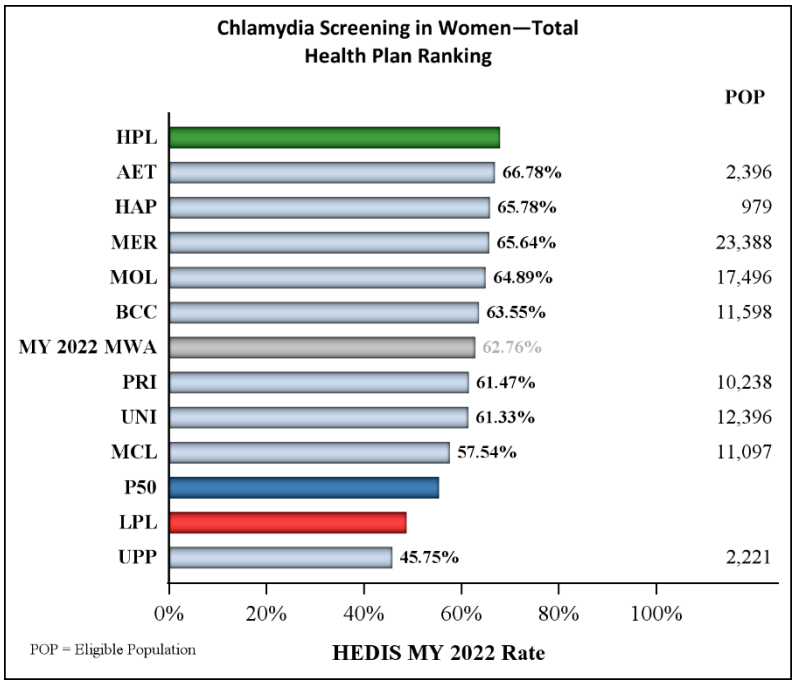
Chlamydia Screening in Women—Total

Chlamydia Screening in Women—Total assesses the percentage of women 16 to 24 years of age who were identified as sexually active and had at least one test for chlamydia during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.

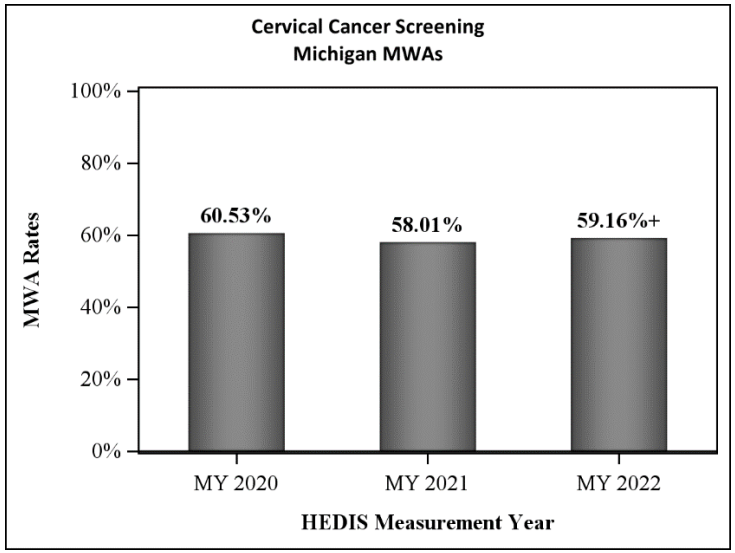


Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 21 percentage points.

Cervical Cancer Screening

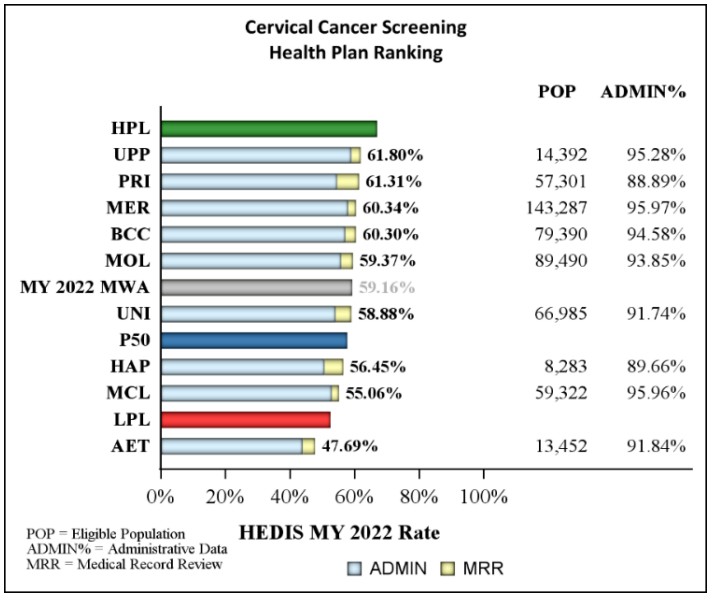
Cervical Cancer Screening assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 to 64 years of age who had cervical cytology performed within the last 3 years.
- Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30 to 64 years of age who had cervical cytology/hrHPV co-testing within the last 5 years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

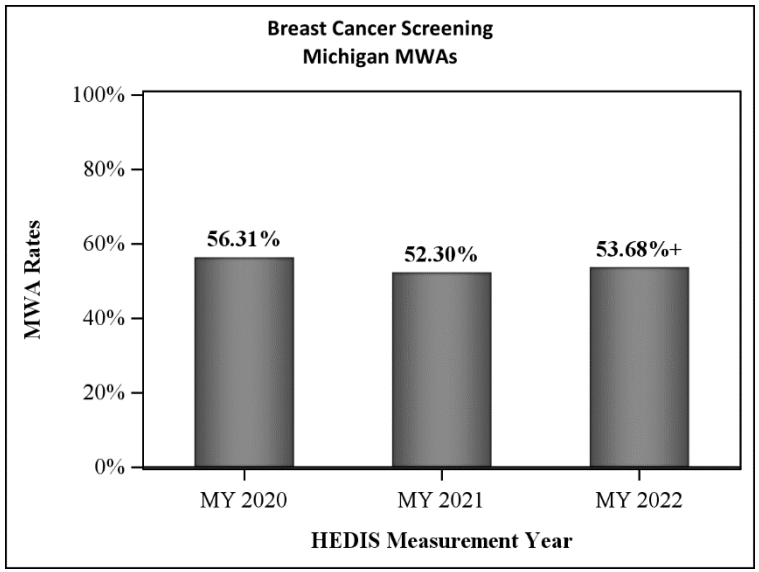
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 14 percentage points.

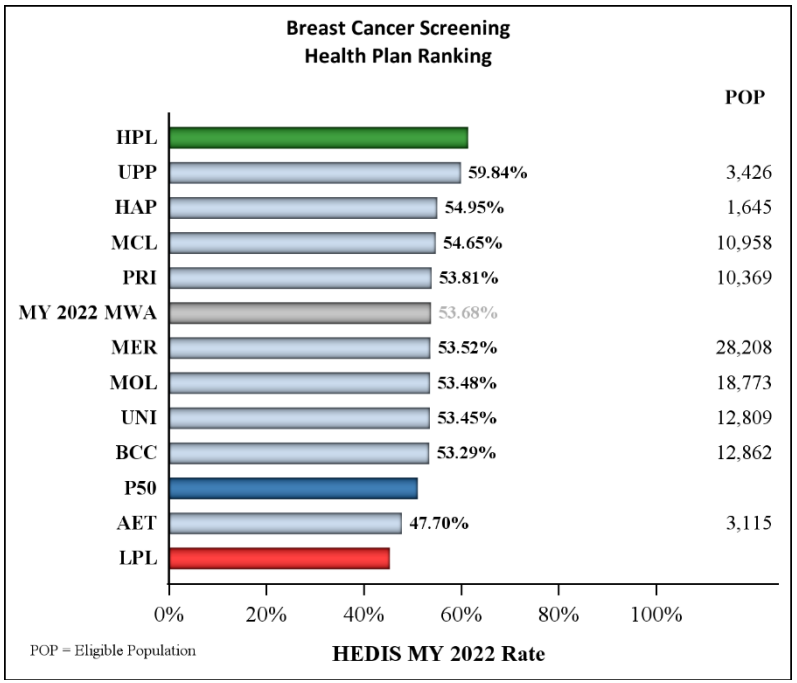
Breast Cancer Screening

Breast Cancer Screening assesses the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Eight MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 12 percentage points.

5. Access to Care

Introduction

The Access to Care domain encompasses the following HEDIS measures:

- *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years, Ages 45 to 64 Years, Ages 65 Years and Older,* and *Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older,* and *Total*
- *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older,* and *Total*
- *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years, Ages 18 to 64 Years, Ages 65 Years and Older,* and *Total*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 5-1 presents the Michigan MWA performance for the measure indicators under the Access to Care domain. The table lists the HEDIS MY 2022 MWA rates and performance levels, a comparison of the HEDIS MY 2021 MWA to the HEDIS MY 2022 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2021 MWA to HEDIS MY 2022 MWA.

Table 5-1—HEDIS MY 2022 MWA Performance Levels and Trend Results for Access to Care

Measure	HEDIS MY 2022 MWA and Performance Level[1]	HEDIS MY 2021 MWA–HEDIS MY 2022 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2022	Number of MHPs With Statistically Significant Decline in HEDIS MY 2022
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20 to 44 Years	72.86%	**-2.52**$^{++}$	0	8
Ages 45 to 64 Years	82.59%	**-1.47**$^{++}$	0	8
Ages 65 Years and Older	89.52%	-0.03	0	0
Total	76.43%	**-2.15**$^{++}$	0	8

Measure	HEDIS MY 2022 MWA and Performance Level[1]	HEDIS MY 2021 MWA–HEDIS MY 2022 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2022	Number of MHPs With Statistically Significant Decline in HEDIS MY 2022
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Ages 3 Months to 17 Years	66.30%	+1.37	3	1
Ages 18 to 64 Years	40.61%	**-5.16^{++}**	0	5
Ages 65 Years and Older	32.23%	-8.71	0	0
Total	54.40%	**+2.62^{+}**	4	0
Appropriate Testing for Pharyngitis [3]				
Ages 3 to 17 Years	69.83%	+0.79	2	1
Ages 18 to 64 Years	54.43%	+0.88	2	0
Ages 65 Years and Older	22.51%	+7.73	0	0
Total	62.63%	**+2.05^{+}**	5	0
Appropriate Treatment for Upper Respiratory Infection				
Ages 3 Months to 17 Years	92.48%	**-1.63^{++}**	0	7
Ages 18 to 64 Years	81.42%	**-0.79^{++}**	1	3
Ages 65 Years and Older	70.18%	-5.33	0	1
Total	88.99%	**-0.60^{++}**	0	6

[1] 2022 performance levels were based on comparisons of the HEDIS MY 2022 MWA rates to national Medicaid Quality Compass HEDIS MY 2021 MWA benchmarks. 2022 performance levels represent the following percentile comparisons:

<25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] HEDIS MY 2021 MWA to HEDIS MY 2022 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

[3] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.

Green Shading^{+} *Indicates that the HEDIS MY 2022 MWA demonstrated a significant improvement from the HEDIS MY 2021 MWA.*

Red Shading^{++} *Indicates that the HEDIS MY 2022 MWA demonstrated a significant decline from the HEDIS MY 2021 MWA.*

Table 5-1 shows that for the Access to Care domain, the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* and *Appropriate Testing for Pharyngitis—Total* measure indicators demonstrated significant improvement from the HEDIS MY 2021 MWA. Upper Peninsula, Priority, and Meridian ranked above the 50th percentile for the most measure indicators within the Access to Care domain. In addition, Upper Peninsula ranked above the HPL for *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older*; *Appropriate Testing for Pharyngitis—Ages 18–64 Years*, and *Total* measure indicators.

The MWA demonstrated a significant decline for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years*, *Ages 45 to 64 Years*, and *Total; Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years*; and *Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years*, *Ages 18 to 64 Years*, and *Total* measure indicators. The measure indicator with the most significant decline was *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years,* with an MWA decrease of 5 percentage points from HEDIS MY 2021. Additionally, the MWA ranked below the 25th percentile for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older* and *Appropriate Testing for Pharyngitis—Ages 3 to 17 Years* measure indicators, with no significant improvement.

MDHHS should conduct ongoing monitoring of the MHPs' performance and declining rates across the Access to Care domain. Underperforming MHPs for this domain should be given suggested interventions, based on MHP-specific capabilities, to improve rates. Improved rates for *Adults' Access to Preventive/Ambulatory Health Services*, *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*, *Appropriate Testing for Pharyngitis*, and *Appropriate Treatment for Upper Respiratory Infection* would have a positive impact on member healthcare outcomes. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help address acute issues or manage chronic conditions.[5-1] Antibiotic-resistant infections can lead to increased healthcare costs, and most importantly, to increased morbidity and mortality. The most important modifiable risk factor for antibiotic resistance is inappropriate prescribing of antibiotics.[5-2] Proper testing and treatment of pharyngitis prevents the spread of sickness while reducing unnecessary use of antibiotics.[5-3]

[5-1] National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services. Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Sept 1, 2023.

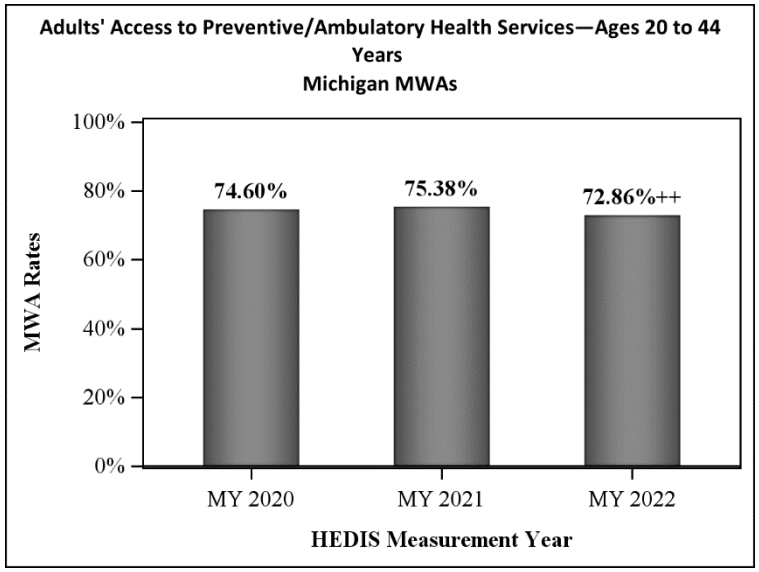
[5-2] Centers for Disease Control and Prevention. Core Elements of Outpatient Antibiotic Stewardship. Available at: https://www.cdc.gov/antibiotic-use/core-elements/outpatient.html. Accessed on: Sept 1, 2023.

[5-3] National Committee for Quality Assurance. Appropriate Testing for Pharyngitis. Available at: https://www.ncqa.org/hedis/measures/appropriate-testing-for-children-with-pharyngitis/. Accessed on: Sept 14, 2023.

Measure-Specific Findings

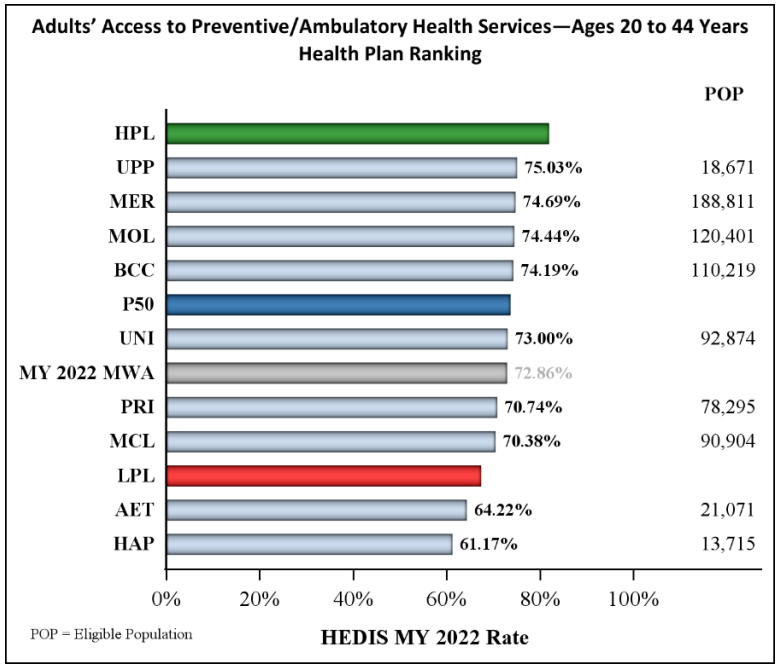
Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years

Adults' Access to Preventive/Ambulatory Health Services—Ages 20 to 44 Years assesses the percentage of members 20 to 44 years of age who had an ambulatory or preventive care visit during the MY.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

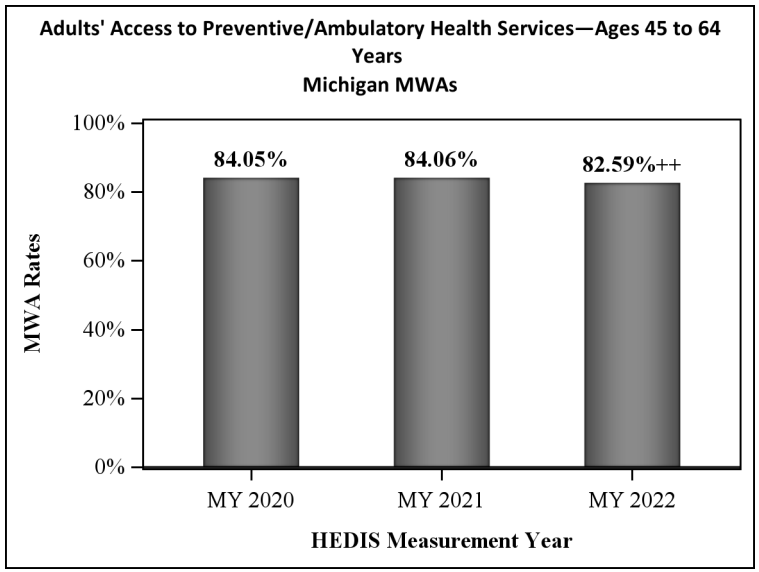
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



Four MHPs ranked above the 50th percentile but fell below the HPL. Three MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 13 percentage points.

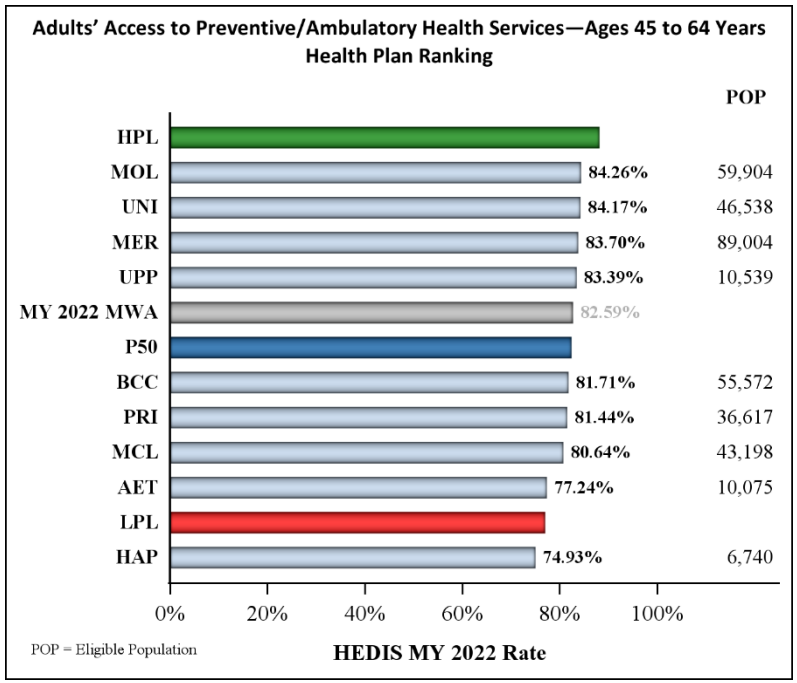
Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years

Adults' Access to Preventive/Ambulatory Health Services—Ages 45 to 64 Years assesses the percentage of members 45 to 64 years of age who had an ambulatory or preventive care visit during the MY.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

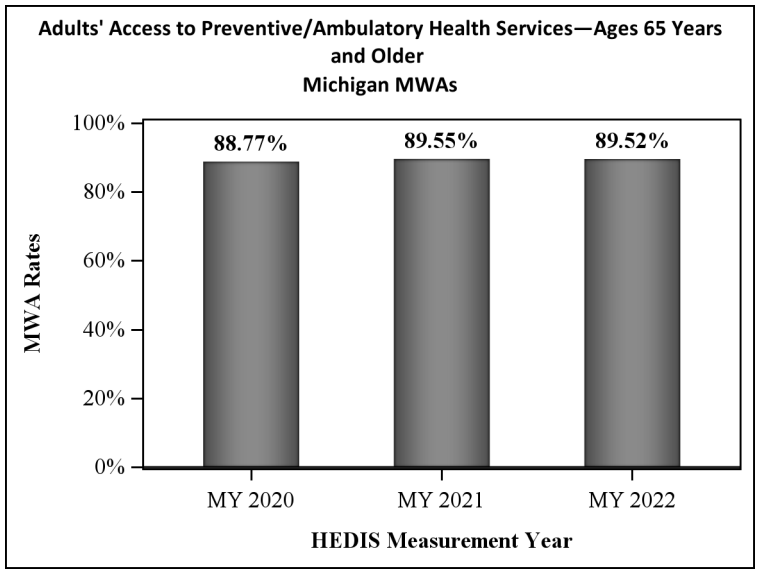
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



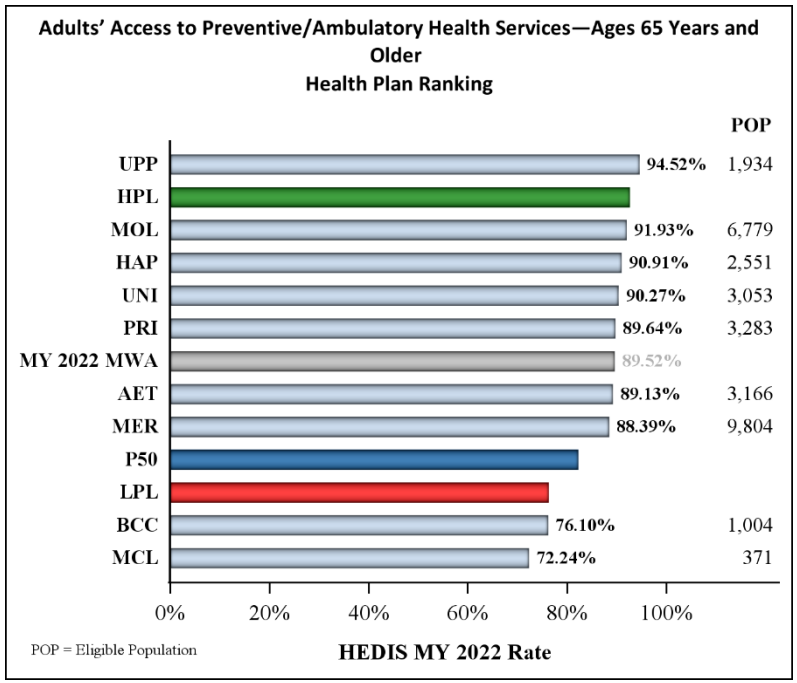
Four MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Four MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 9 percentage points.

Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older

Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older assesses the percentage of members 65 years of age and older who had an ambulatory or preventive care visit during the MY.



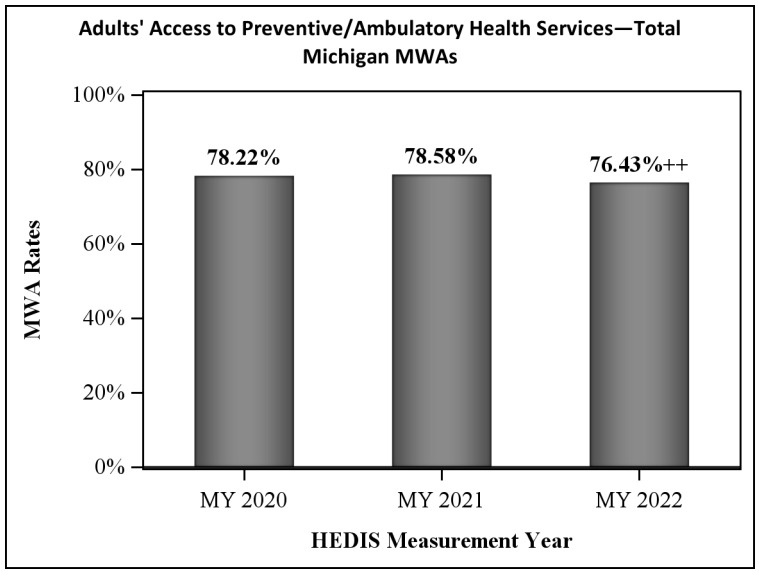
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



One MHP ranked above the HPL. Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs fell below the LPL. MHP performance varied by over 22 percentage points.

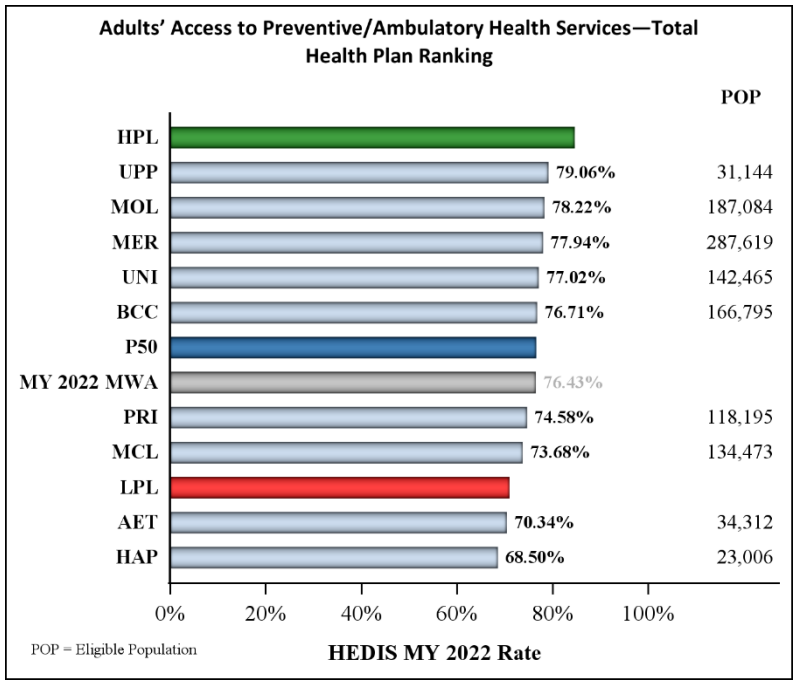
Adults' Access to Preventive/Ambulatory Health Services—Total

Adults' Access to Preventive/Ambulatory Health Services—Total assesses the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the MY.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

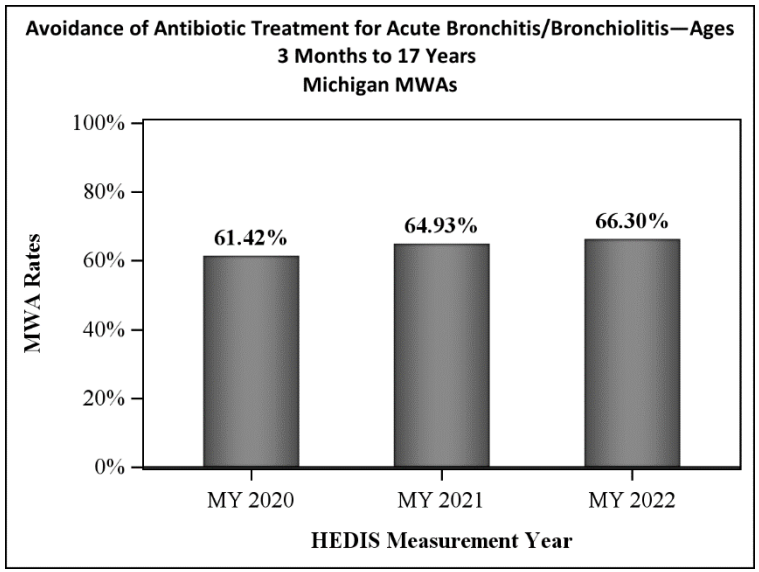
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



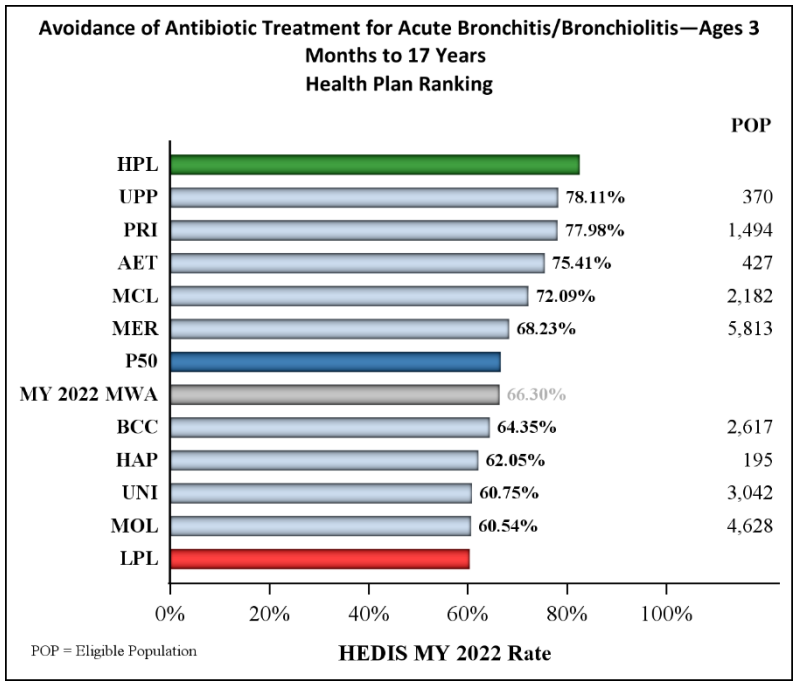
Five MHPs ranked above the 50th percentile but fell below the HPL. Two MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 10 percentage points.

Avoidance of Antibiotic Treatment in for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years assesses the percentage of members 3 months to 17 years of age with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.



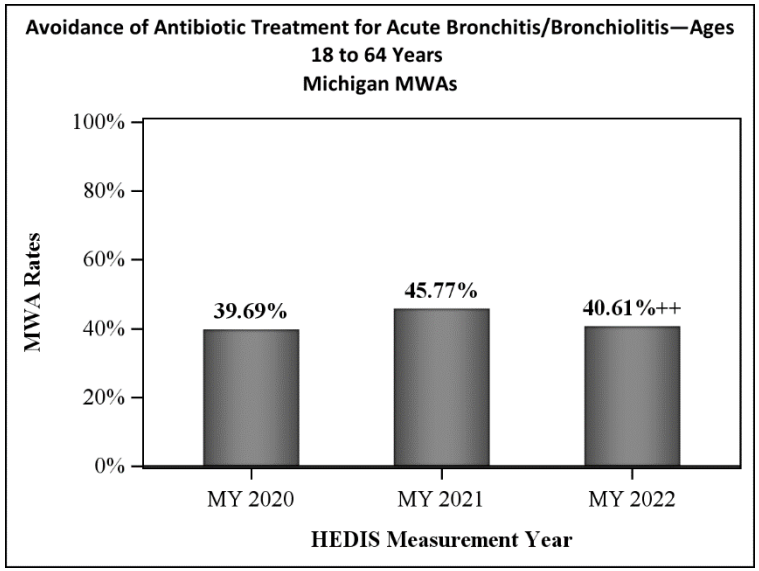
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



Five MHPs ranked above the 50th percentile but fell below the HPL. Four MHPs and the MWA ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 17 percentage points.

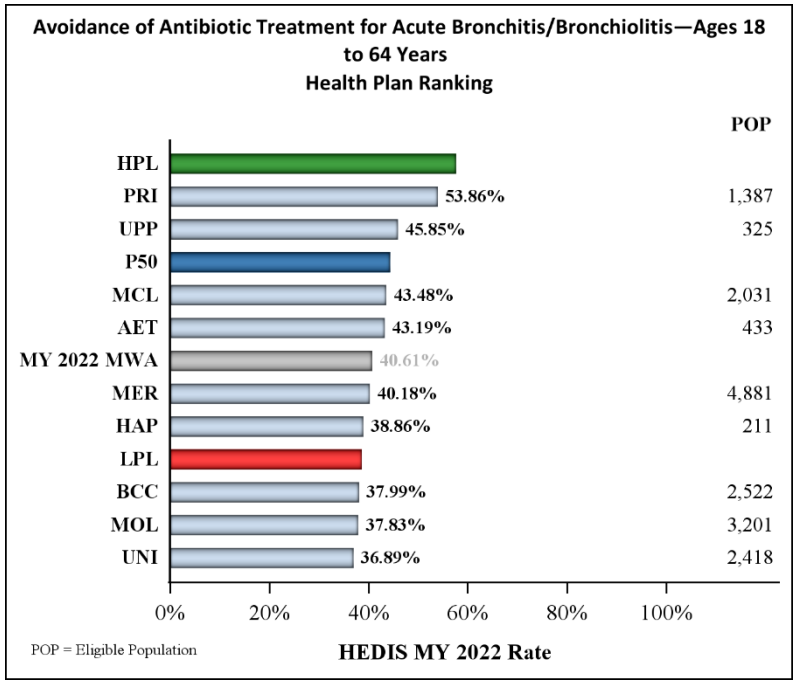
Avoidance of Antibiotic Treatment in for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

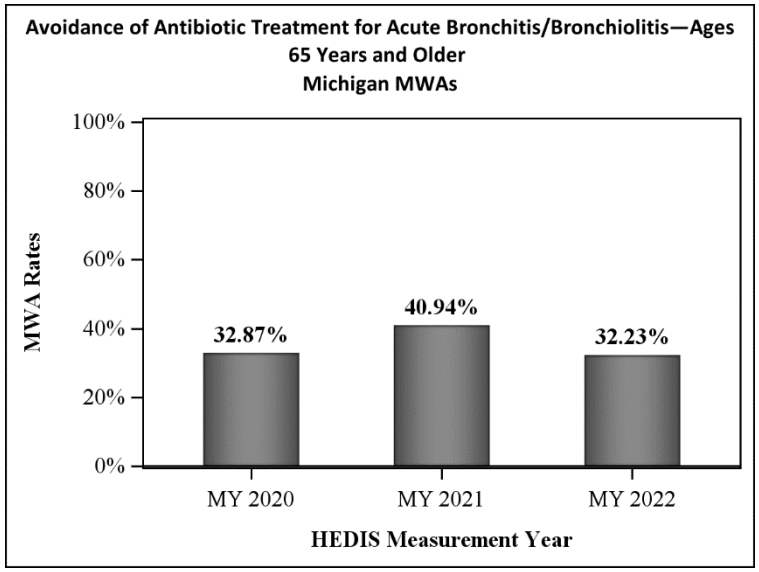
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



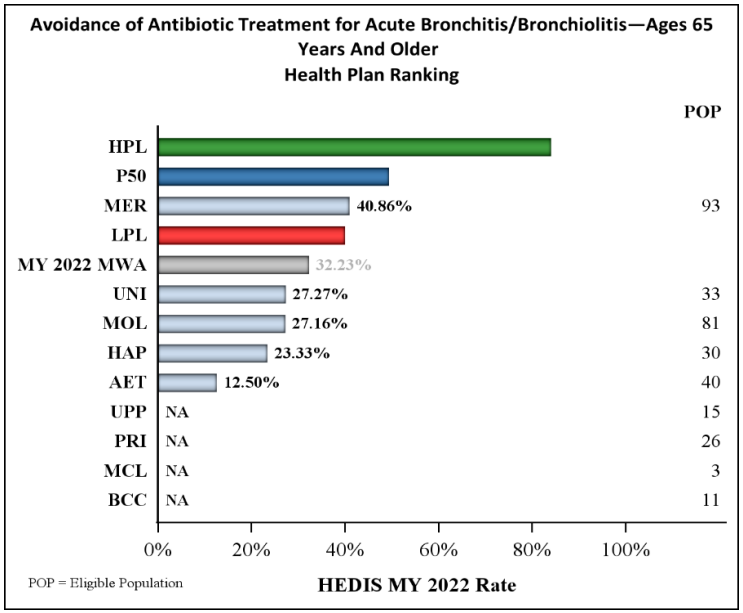
Two MHPs ranked above the 50th percentile but fell below the HPL. Four MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Three MHPs fell below the LPL. MHP performance varied by over 16 percentage points.

Avoidance of Antibiotic Treatment in for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 65 Years and Older assesses the percentage of members 65 years of age and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.



The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.

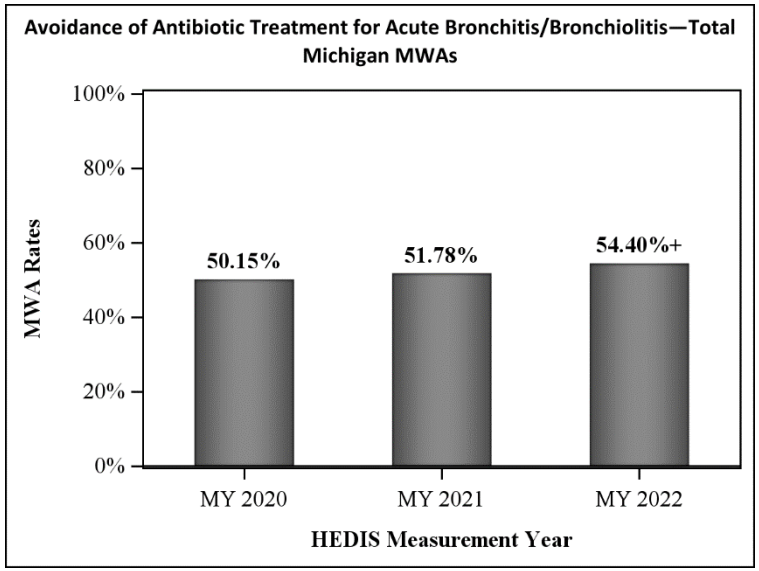


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MHP ranked above the LPL but fell below the 50th percentile. Four MHPs and the MWA fell below the LPL. MHP performance varied by over 28 percentage points.

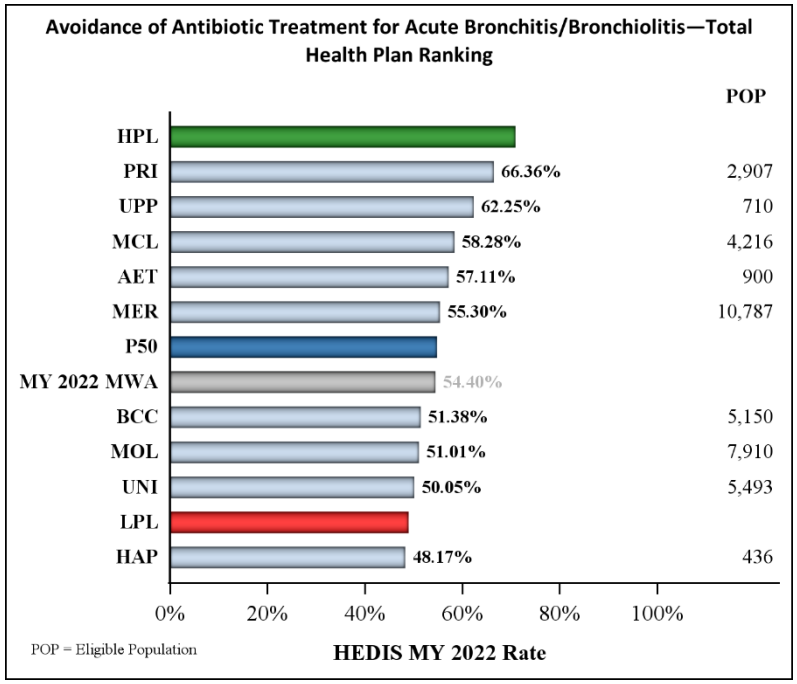
Avoidance of Antibiotic Treatment in for Acute Bronchitis/Bronchiolitis—Total

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total assesses the percentage of members 3 months of age or older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

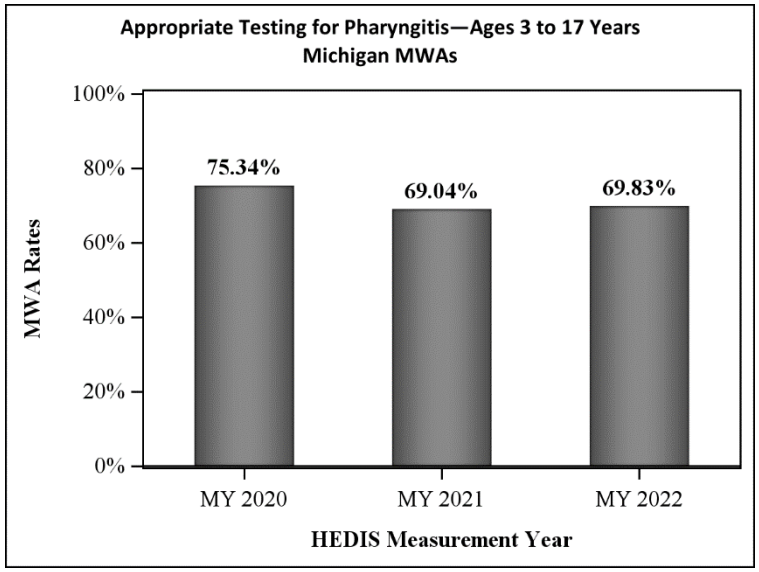
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



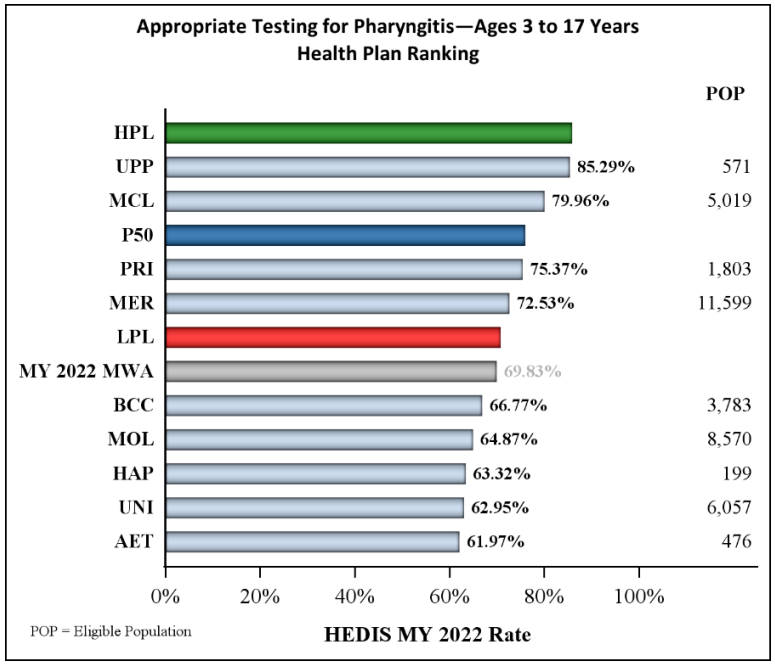
Five MHPs ranked above the 50th percentile but fell below the HPL. Three MHPs and the MWA ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 18 percentage points.

Appropriate Testing for Pharyngitis—Ages 3 to 17 Years

Appropriate Testing for Pharyngitis—Ages 3 to 17 Years assesses the percentage of episodes for members 3 to 17 years where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.*



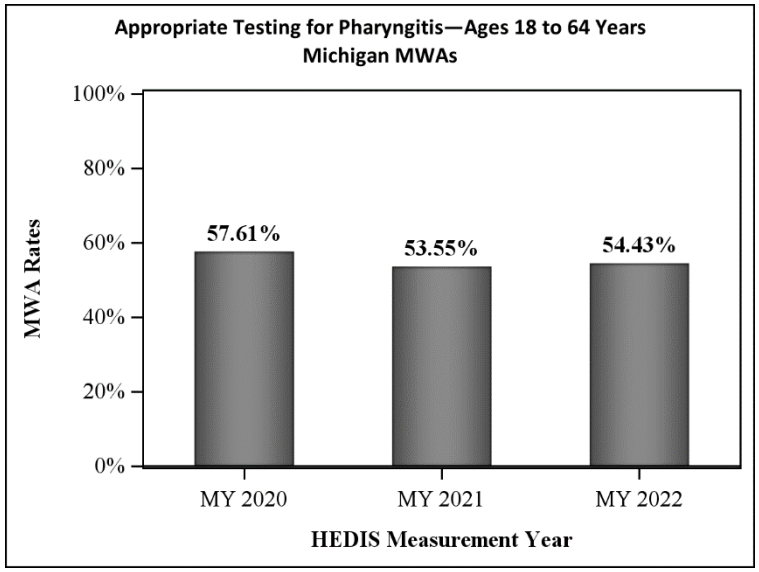
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021 MWA.



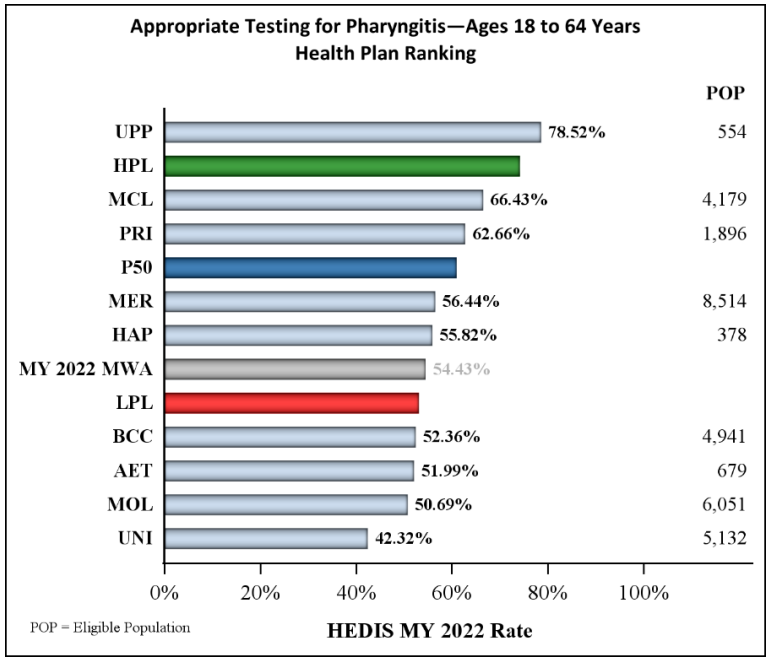
Two MHPs ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. Five MHPs and the MWA fell below the LPL. MHP performance varied by over 23 percentage points.

Appropriate Testing for Pharyngitis—Ages 18 to 64 Years

Appropriate Testing for Pharyngitis—Ages 18 to 64 Years assesses the percentage of episodes for members 18 to 64 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A strep test for the episode. *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.*



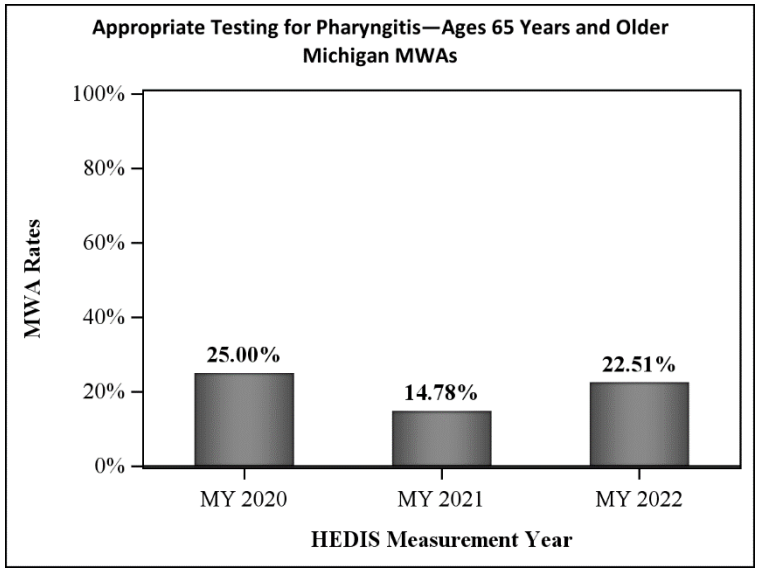
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021 MWA.



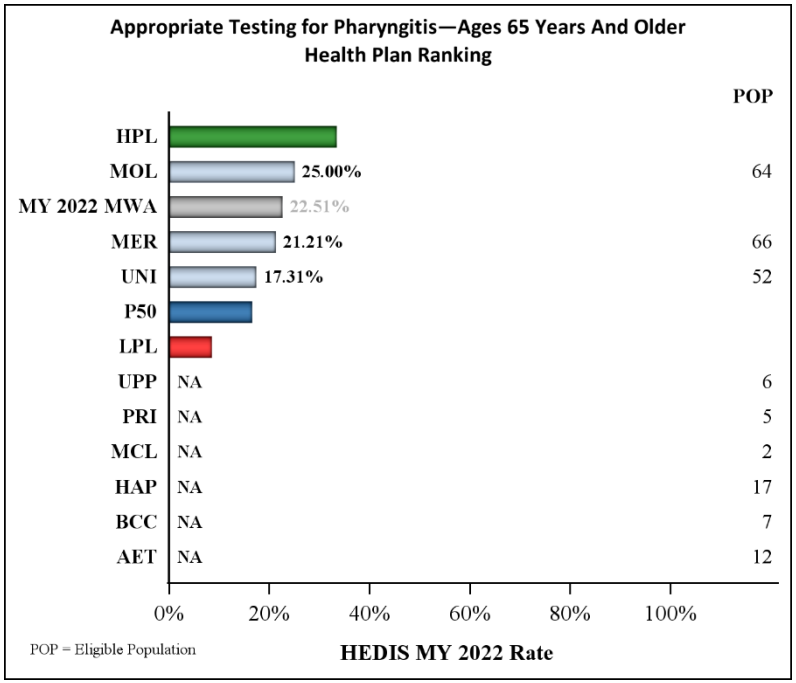
One MHP ranked above the HPL. Two MHPs ranked above the 50th percentile but fell below the HPL. Two MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Four MHPs fell below the LPL. MHP performance varied by over 36 percentage points.

Appropriate Testing for Pharyngitis—Ages 65 Years and Older

Appropriate Testing for Pharyngitis—Ages 65 Years and Older assesses the percentage of episodes for members 65 years of age and older who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A strep test for the episode. *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.*



The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021 MWA.

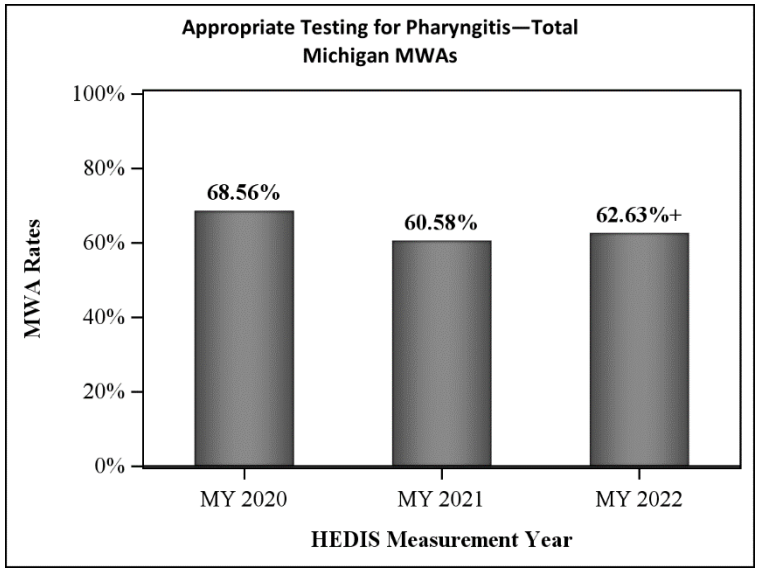


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Three MHPs and the MWA ranked above the 50th percentile but fell below the HPL. MHP performance varied by over 7 percentage points.

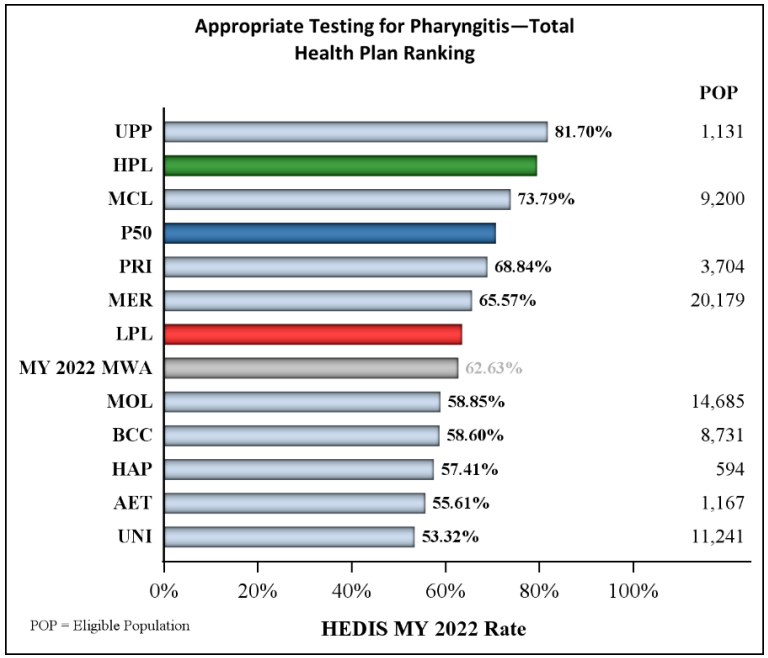
Appropriate Testing for Pharyngitis—Total

Appropriate Testing for Pharyngitis—Total assesses the percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A strep test for the episode. *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.*



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

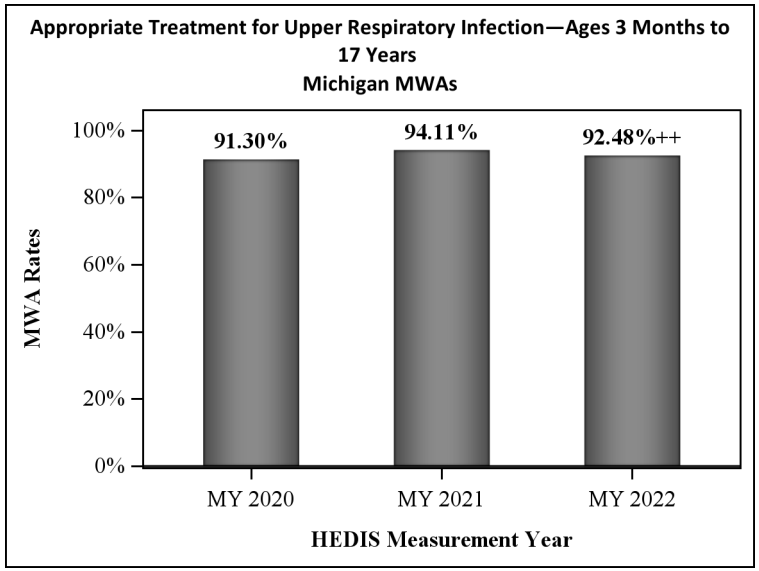
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



One MHP ranked above the HPL. One MHP ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. Five MHPs and the MWA fell below the LPL. MHP performance varied by over 28 percentage points.

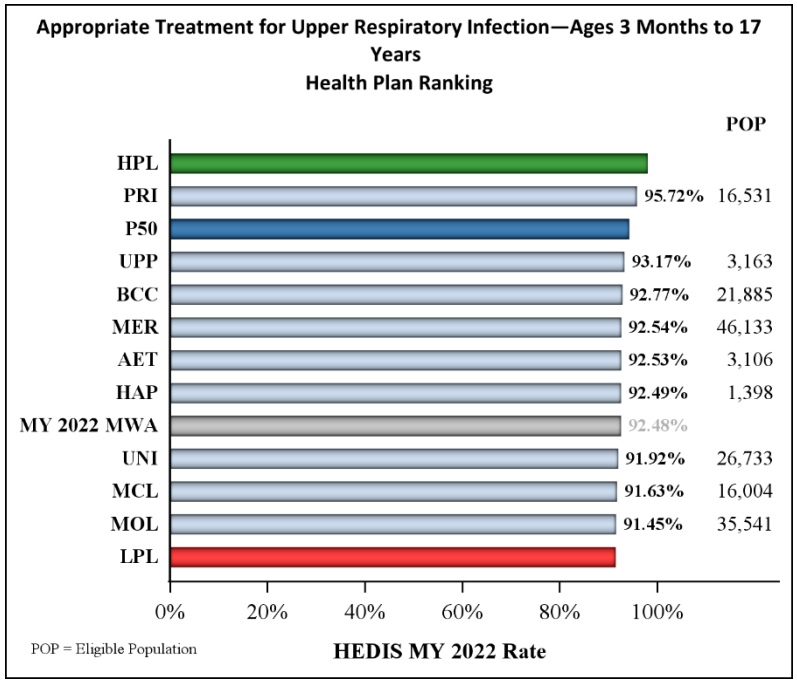
Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years

Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years assesses the percentage of members 3 months to 17 years of age with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

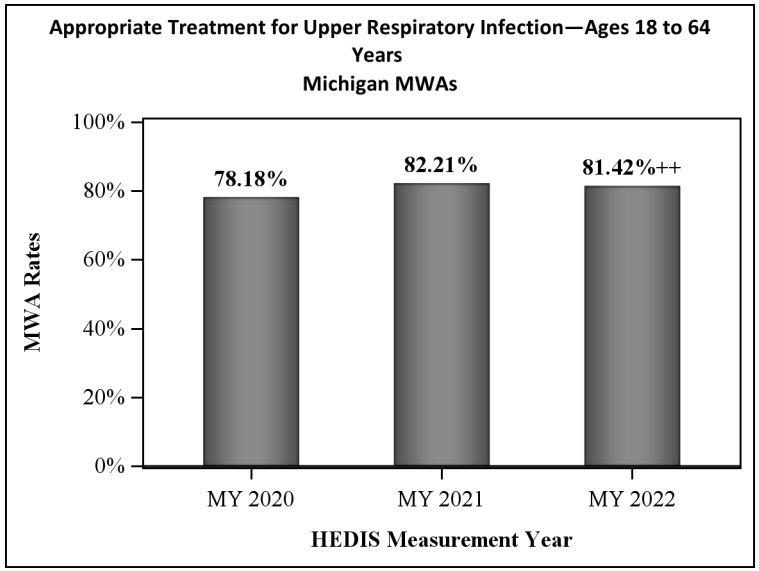
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



One MHP ranked above the 50th percentile but fell below the HPL. Eight MHPs and the MWA ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 4 percentage points.

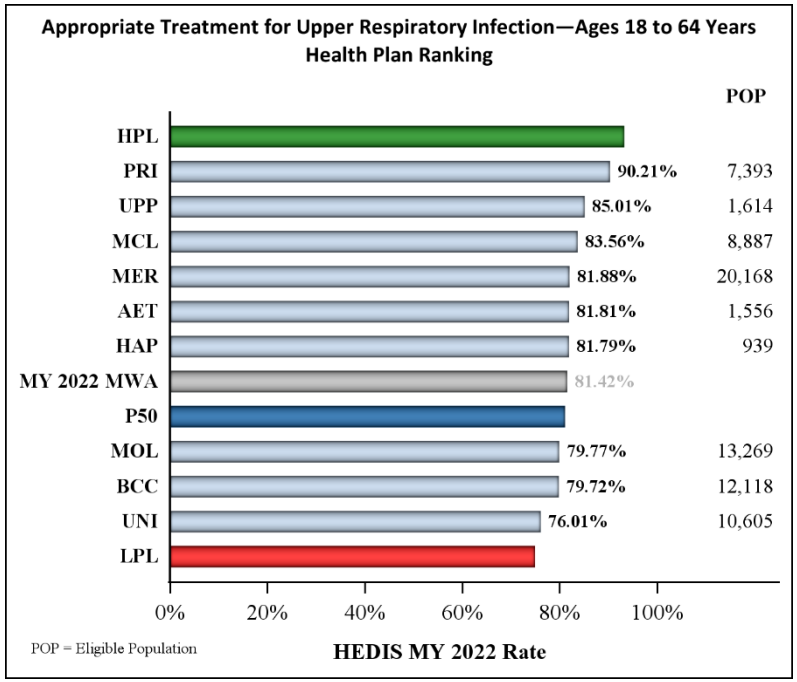
Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years

Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age with a diagnosis of URI that did not result in an antibiotic dispensing event.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

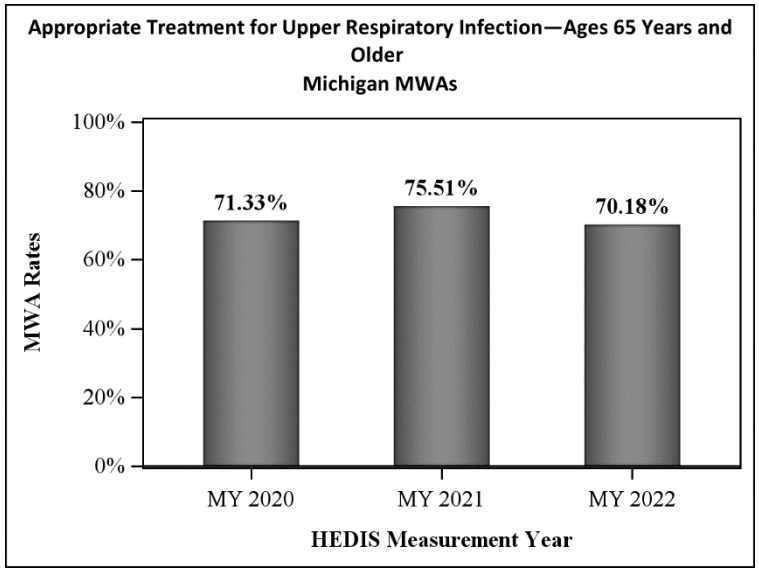
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



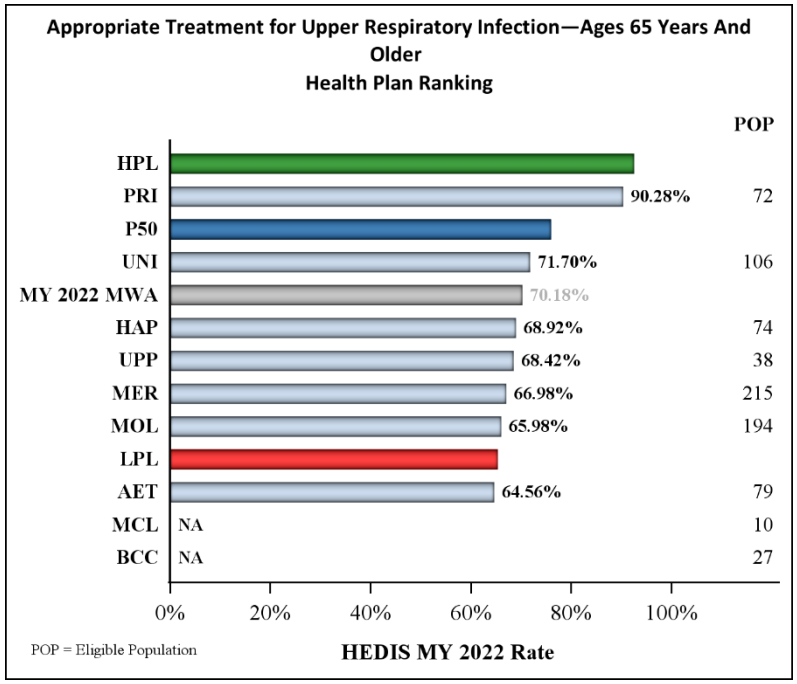
Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Three MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 14 percentage points.

Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older

Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years and Older assesses the percentage of members 65 years of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event.



The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021 MWA.

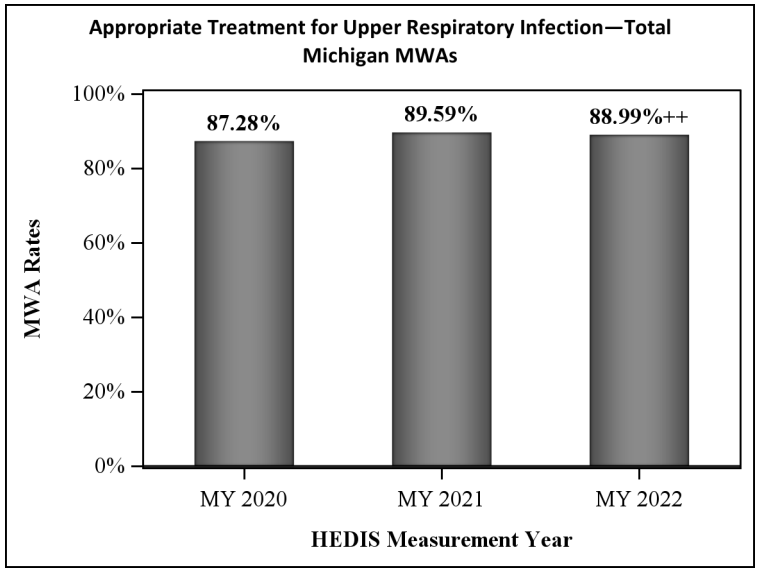


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MHP ranked above the 50th percentile but fell below the HPL. Five MHPs and the MWA ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 25 percentage points.

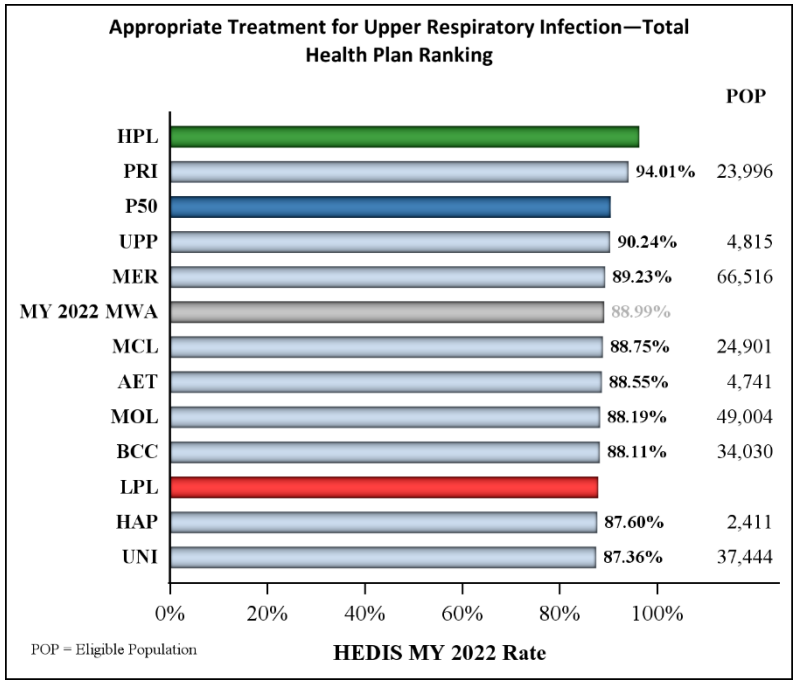
Appropriate Treatment for Upper Respiratory Infection—Total

Appropriate Treatment for Upper Respiratory Infection—Total assesses the percentage of episodes for members 3 months of age and older with a diagnosis of URI that did not result in an antibiotic dispensing event.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



One MHP ranked above the 50th percentile but fell below the HPL. Six MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 6 percentage points.

6. Obesity

Introduction

The Obesity domain encompasses the following HEDIS measures:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 6-1 presents the Michigan MWA performance for the measure indicators under the Obesity domain. The table lists the HEDIS MY 2022 MWA rates and performance levels, a comparison of the HEDIS MY 2021 MWA to the HEDIS MY 2022 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2021 MWA to HEDIS MY 2022 MWA.

Table 6-1—HEDIS MY 2022 MWA Performance Levels and Trend Results for Obesity

Measure	HEDIS MY 2022 MWA and Performance Level[1]	HEDIS MY 2021 MWA–HEDIS MY 2022 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2022	Number of MHPs With Statistically Significant Decline in HEDIS MY 2022
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	80.54%	**+3.67⁺**	1	0
Counseling for Nutrition—Total	70.88%	**+0.76⁺**	0	0
Counseling for Physical Activity—Total	69.40%	**+0.50⁺**	0	0

[1] HEDIS MY 2022 performance levels were based on comparisons of the HEDIS MY 2022 MWA rates to national Medicaid Quality Compass HEDIS MY 2021 MWA benchmarks. HEDIS MY 2022 performance levels represent the following percentile comparisons:

<25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] HEDIS MY 2021 MWA to HEDIS MY 2022 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

Green Shading⁺ *Indicates that the HEDIS MY 2022 MWA demonstrated a significant improvement from the HEDIS MY 2021 MWA.*

Red Shading⁺⁺ *Indicates that the HEDIS MY 2022 MWA demonstrated a significant decline from the HEDIS MY 2021 MWA.*

Table 6-1 shows that for the Obesity domain, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Counseling for Physical Activity—Total* measure indicators were an area of strength. Both measure indicators ranked at or above the 50th percentile and demonstrated significant improvement from the HEDIS MY 2021 MWA. Additionally, Upper Peninsula, Blue Cross, Priority, UnitedHealthcare, Aetna, and HAP ranked above the 50th percentile for the most measure indicators within the Obesity domain. Priority and Upper Peninsula ranked above the HPL for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicator.

While the MY 2022 MWA for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator significantly increased from the MY 2021 MWA, it ranked below the 50th percentile, demonstrating an area for further improvement. Additionally, McLaren fell below the LPL for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators.

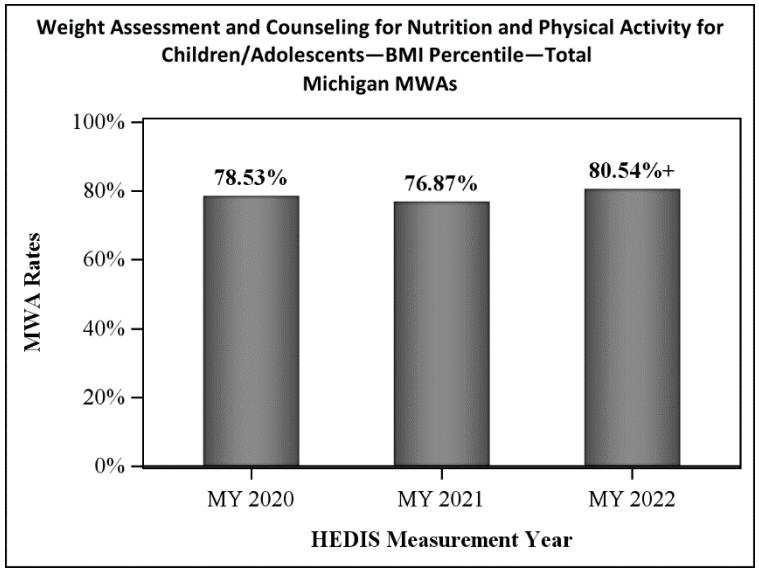
MDHHS should continue to monitor the MHPs' performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator and work with the MHPs and providers to strategize the best way to utilize every office visit or virtual visit to encourage a healthy lifestyle and provide education on healthy habits for children and adolescents. Additionally, MDHHS should continue to monitor McLaren's performance for this measure to ensure the MHP performance does not continue to decline and encourage higher-performing MHPs to share and discuss best practices. Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases. Obesity can become a lifelong health issue; therefore, it is important to monitor weight problems in children and adolescents and provide guidance for maintaining a healthy weight and lifestyle.[6-1]

[6-1] National Committee for Quality Assurance. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. Available at: https://www.ncqa.org/hedis/measures/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents/. Accessed on: Sept 1, 2023.

Measure-Specific Findings

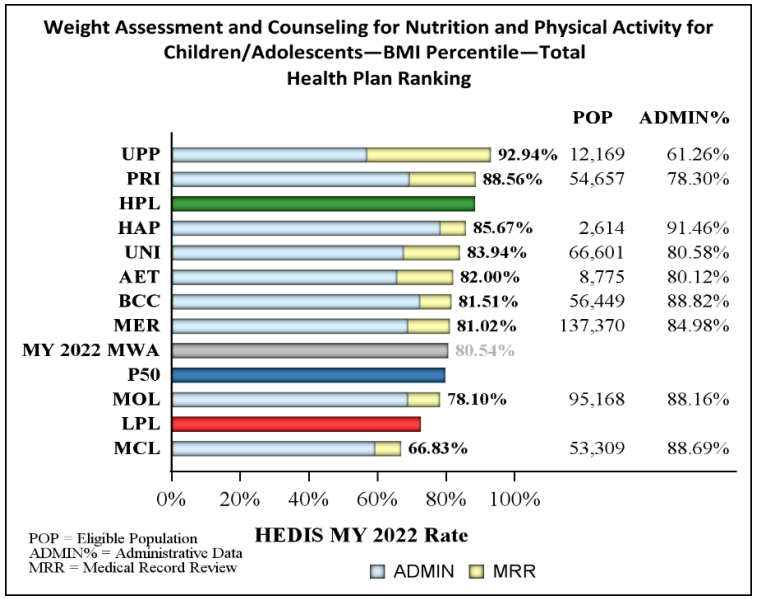
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of BMI percentile documentation during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

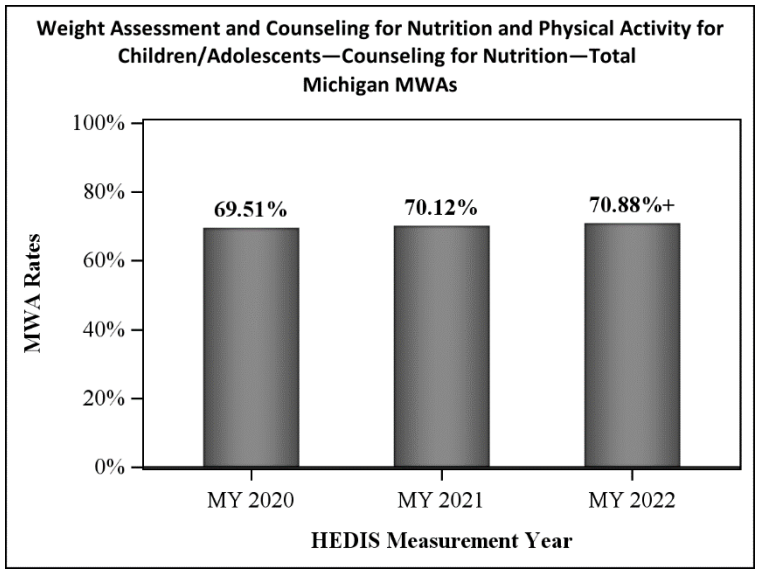
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Two MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 26 percentage points.

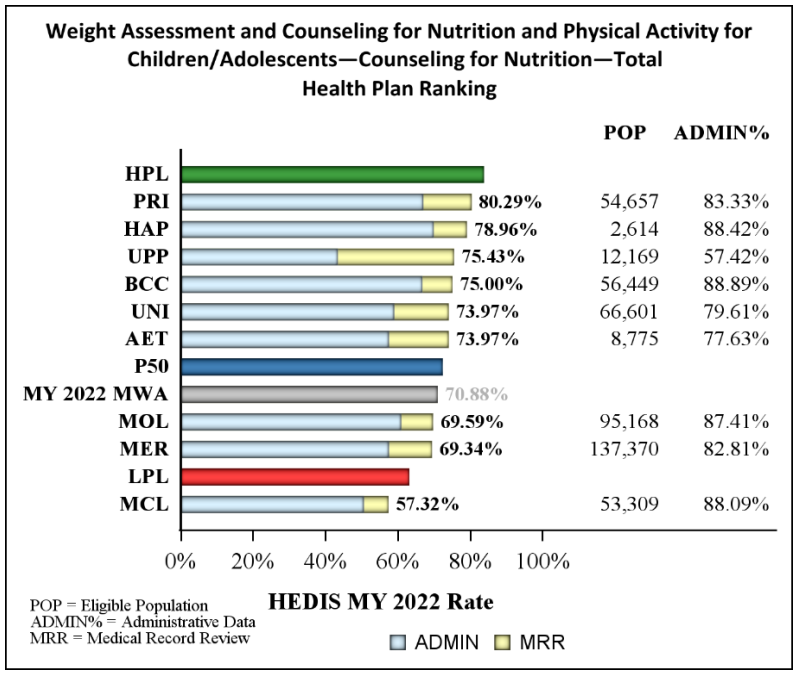
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of counseling for nutrition during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

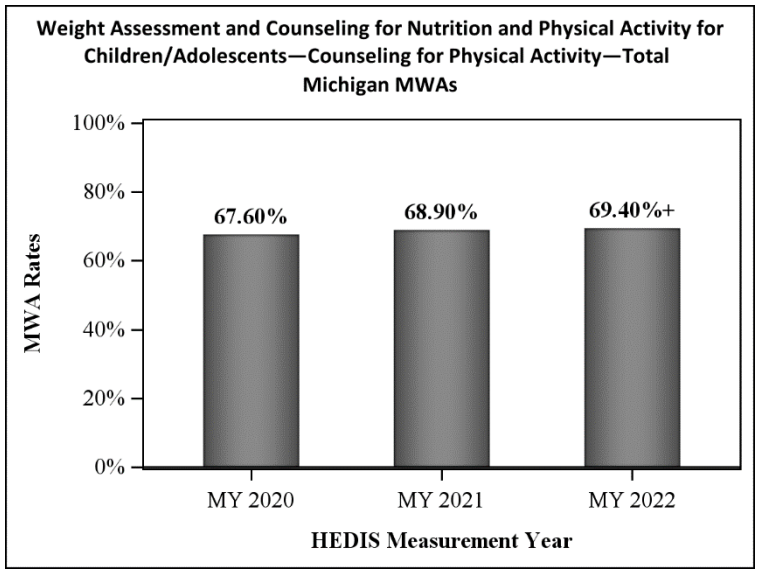
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Six MHPs ranked above the 50th percentile but fell below the HPL. Two MHPs and the MWA ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 22 percentage points.

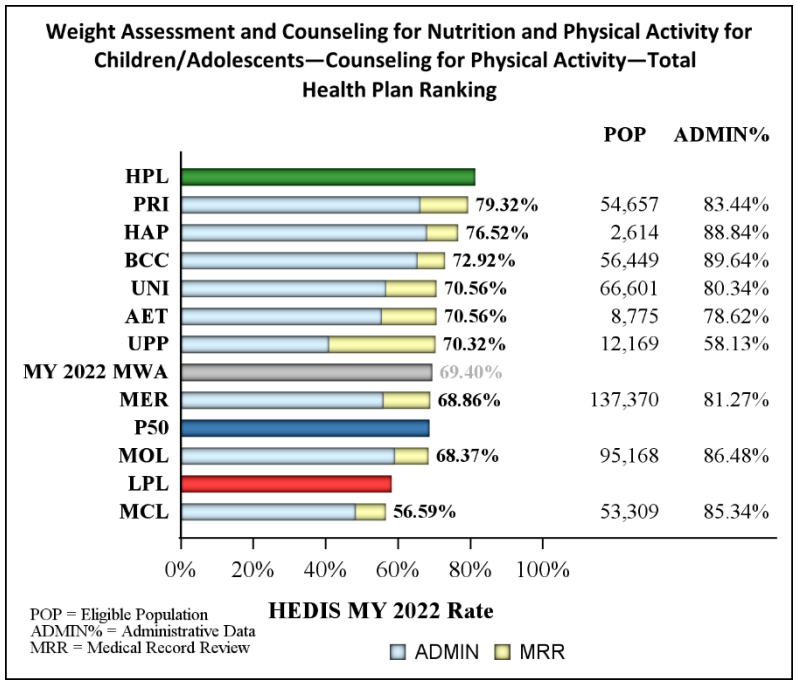
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total assesses the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of counseling for physical activity during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Seven MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 22 percentage points.

7. Pregnancy Care

Introduction

The Pregnancy Care domain encompasses the following HEDIS measure:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 7-1 presents the Michigan MWA performance for the measure indicators under the Pregnancy Care domain.

Table 7-1—HEDIS MY 2022 MWA Performance Levels and Trend Results for Pregnancy Care

Measure	HEDIS MY 2022 MWA and Performance Level[1]	HEDIS MY 2021 MWA–HEDIS MY 2022 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2022	Number of MHPs With Statistically Significant Decline in HEDIS MY 2022
Prenatal and Postpartum Care				
Timeliness of Prenatal Care [3]	78.45%	**-1.00**++	0	0
Postpartum Care	75.33%	**+1.97**+	1	0

[1] *HEDIS MY 2022 performance levels were based on comparisons of the HEDIS MY 2022 MWA rates to national Medicaid Quality Compass HEDIS MY 2021 MWA benchmarks. HEDIS MY 2022 performance levels represent the following percentile comparisons:*

<25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] *HEDIS MY 2021 MWA to HEDIS MY 2022 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.*

[3] *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.*

Green Shading+ *Indicates that the HEDIS MY 2022 MWA demonstrated a significant improvement from the HEDIS MY 2021 MWA.*

Red Shading++ *Indicates that the HEDIS MY 2022 MWA demonstrated a significant decline from the HEDIS MY 2021 MWA.*

Table 7-1 shows that for the Pregnancy Care domain, *Prenatal and Postpartum Care—Postpartum Care* was an area of strength, as the measure indicator demonstrated significant improvement from the HEDIS MY 2021 MWA. Additionally, Upper Peninsula, Blue Cross, and Priority ranked above the 50th percentile for at least one of the measure indicators within the Pregnancy Care domain, with Upper Peninsula ranking above the HPL for both *Timeliness of Prenatal Care* and *Postpartum Care* measure indicators.

Molina, Priority, UnitedHealthcare, HAP, Meridian, McLaren, and Aetna all fell below the LPL for *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; and Molina, HAP, and Aetna all fell below the LPL for *Prenatal and Postpartum Care—Postpartum Care*.

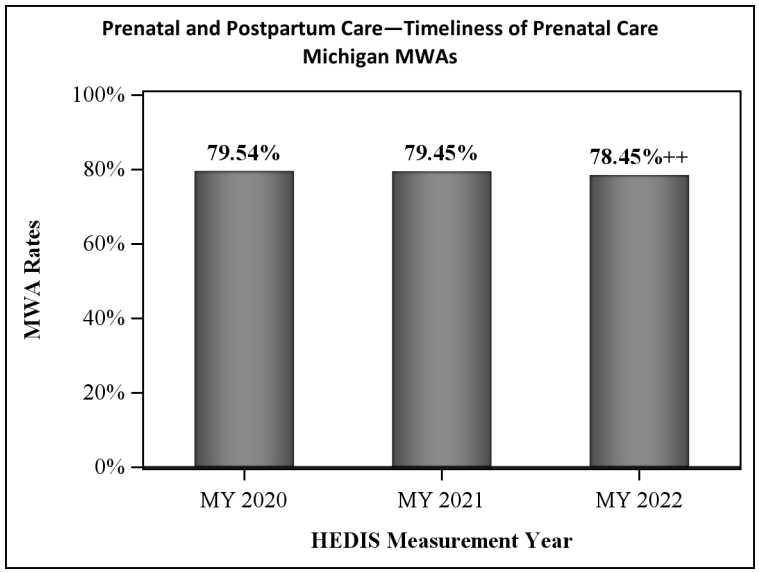
Timely and adequate prenatal and postpartum care can set the stage for long-term health and well-being of new mothers and their infants.[7-1] MDHHS should continue monitoring the MHPs' performance in the Pregnancy Care domain and assess the need for or evaluation of current prenatal and postpartum care coordination programs for lower-performing MHPs. Effective care coordination efforts or programs could potentially assist with scheduling prenatal and postpartum appointments, arranging transportation, and educating members on the importance of keeping appointments. MDHHS is also encouraged to work with the higher-performing MHPs to identify best practices for ensuring women's access to prenatal and postpartum care which can then be shared with the lower-performing MHPs to improve overall access.

[7-1] National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Sept 1, 2023.

Measure-Specific Findings

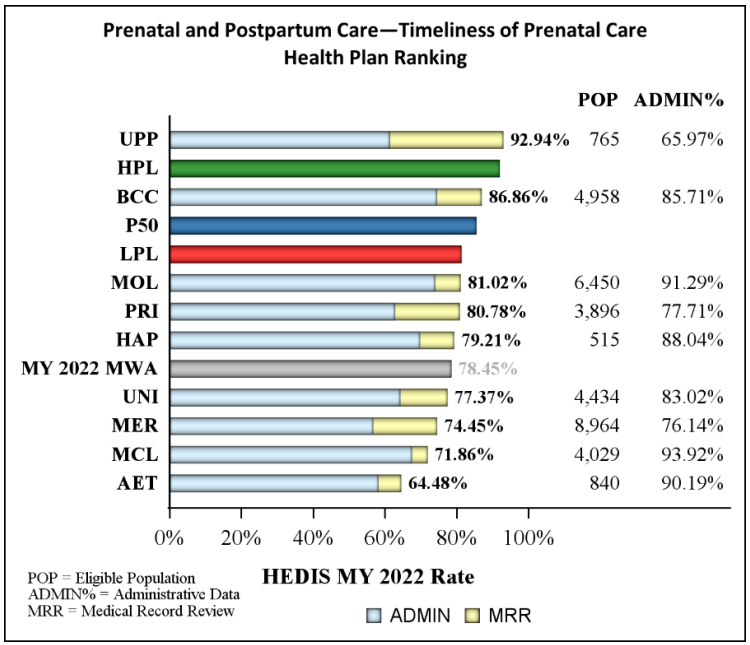
Prenatal and Postpartum Care—Timeliness of Prenatal Care

Prenatal and Postpartum Care—Timeliness of Prenatal Care assesses the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the MHP. *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.*



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

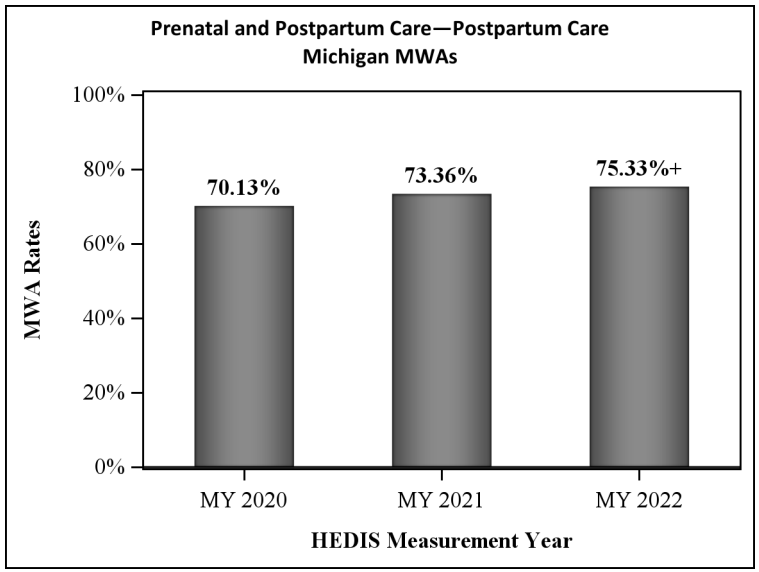
The HEDIS MY 2022 MWA rate significantly declined from HEDIS MY 2021.



One MHP ranked above the HPL. One MHP ranked above the 50th percentile but fell below the HPL. Seven MHPs and the MWA fell below the LPL. MHP performance varied by over 28 percentage points.

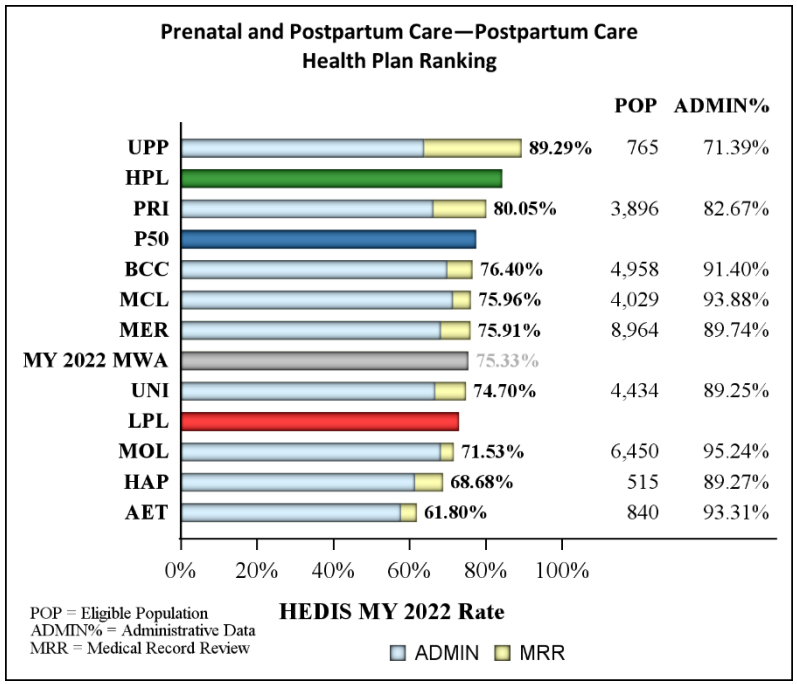
Prenatal and Postpartum Care—Postpartum Care

Prenatal and Postpartum Care—Postpartum Care assesses the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



One MHP ranked above the HPL. One MHP ranked above the 50th percentile but fell below the HPL. Four MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Three MHPs fell below the LPL. MHP performance varied by over 27 percentage points.

8. Living With Illness

Introduction

The Living With Illness domain encompasses the following HEDIS measures:

- *Hemoglobin A1c Control for Patients With Diabetes—Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* and *HbA1c Control (<8.0%)*
- *Blood Pressure Control for Patients With Diabetes*
- *Eye Exam for Patients with Diabetes*
- *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years, Ages 65 to 74 Years, Ages 75 to 85 Years,* and *Total*
- *Asthma Medication Ratio—Total*
- *Controlling High Blood Pressure*
- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendices A, B, and C.

Summary of Findings

Table 8-1 presents the Michigan MWA performance for the measure indicators under the Living With Illness domain. The table lists the HEDIS MY 2022 MWA rates and performance levels, a comparison of the HEDIS MY 2021 MWA to the HEDIS MY 2022 MWA for each measure indicator with trend analysis results, and a summary of the MHPs with rates demonstrating significant changes from HEDIS MY 2021 MWA to HEDIS MY 2022 MWA.

Table 8-1—HEDIS MY 2022 MWA Performance Levels and Trend Results for Living With Illness

Measure	HEDIS MY 2022 MWA and Performance Level[1]	HEDIS MY 2021 MWA–HEDIS MY 2022 MWA Comparison[2]	Number of MHPs With Statistically Significant Improvement in HEDIS MY 2022	Number of MHPs With Statistically Significant Decline in HEDIS MY 2022
Hemoglobin A1c Control for Patients With Diabetes				
*Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**	39.01%	**-4.03+**	2	0
HbA1c Control (<8.0%)	53.53%	**+5.27+**	3	0
Eye Exam for Patients With Diabetes				
Eye Exam (Retinal) Performed	54.81%	+0.25	1	1
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	66.93%	**+7.32+**	5	0
Kidney Health Evaluation for Patients With Diabetes				
Ages 18 to 64 Years	35.09%	**+4.47+**	7	0
Ages 65 to 74 Years	36.52%	**+6.60+**	5	1
Ages 75 to 85 Years	34.44%	+4.17	1	0
Total	35.16%	**+4.59+**	8	0
Asthma Medication Ratio				
Total	57.73%	**+1.37+**	3	0
Controlling High Blood Pressure				
Controlling High Blood Pressure	62.07%	**+5.93+**	3	0
Antidepressant Medication Management				
Effective Acute Phase Treatment	70.03%	**+4.35+**	4	1
Effective Continuation Phase Treatment	56.56%	**+7.25+**	4	1
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.45%	+0.50	2	1
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	66.84%	+1.17	1	1
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	70.31%	+3.92	0	0
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.33%	-1.47	0	1

[1] *HEDIS MY 2022 performance levels were based on comparisons of the HEDIS MY 2021 MWA rates to national Medicaid Quality Compass HEDIS MY 2021 MWA benchmarks. HEDIS MY 2022 performance levels represent the following percentile comparisons:*

<25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] *HEDIS MY 2021 MWA to HEDIS MY 2022 MWA comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.*

** For this indicator, a lower rate indicates better performance.*

Green Shading[+] *Indicates that the HEDIS MY 2022 MWA demonstrated a significant improvement from the HEDIS MY 2021 MWA.*

Red Shading[++] *Indicates that the HEDIS MY 2022 MWA demonstrated a significant decline from the HEDIS MY 2021 MWA.*

Table 8-1 shows that for the Living With Illness domain, the *Hemoglobin A1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%)* and *HbA1c Control (<8.0%)*; *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)*; *Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years*, *Ages 65 to 74 Years*, and *Total*; *Controlling High Blood Pressure*; and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators were areas of significant strength. Most of these measure indicators ranked at or above the 50th percentile, with the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators ranking at or above the 75th and 90th percentiles, respectively. All of these measure indicators also demonstrated significant improvement from the HEDIS MY 2021 MWA. Upper Peninsula, Priority, and UnitedHealthcare ranked above the 50th percentile and the HPL for the most measure indicators within the Living With Illness domain.

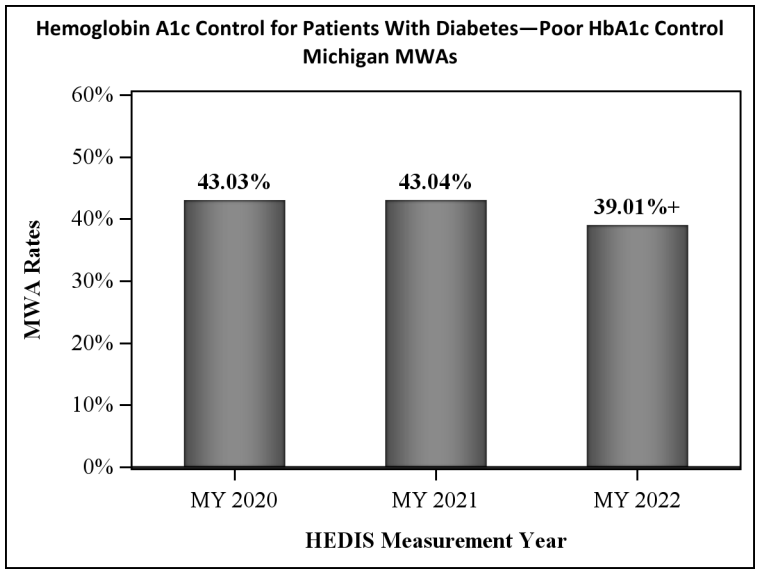
While the HEDIS MY 2022 MWA demonstrated considerable improvement from HEDIS MY 2021 across the Living With Illness domain, the *Asthma Medication Ratio* measure indicator ranked below the 25th percentile, demonstrating an area for improvement. MDHHS is encouraged to continue monitoring MHPs' quality improvement strategies for the Living With Illness domain. MDHHS should work with the MHPs to readily identify interventions and operational process changes that led to increased rates, while supporting and strengthening methods that resulted in improved year- over-year performance. Additionally, the MHPs should focus their efforts on improving performance related to the *Asthma Medication Ratio* measure indicator and health outcomes among people with asthma. The prevalence and cost of asthma has increased over the past decade, demonstrating the need for better access to care and medication. Appropriate medication management for patients with asthma could reduce the need for rescue medication, as well as the costs associated with emergency room visits, inpatient admissions, and missed days of work or school.[8-1]

[8-1] National Committee for Quality Assurance. Asthma Medication Ratio. Available at: https://www.ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio/. Accessed on: Sept 1, 2023.

Measure-Specific Findings

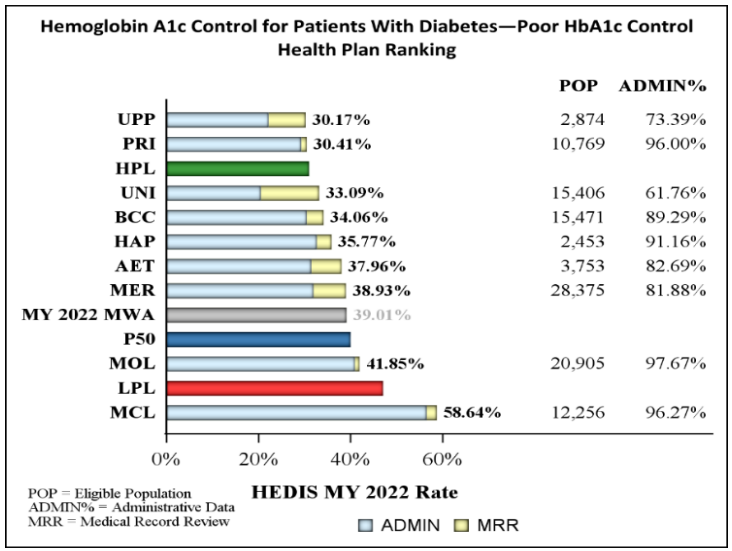
Hemoglobin A1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%)

Hemoglobin A1c Control for Patients With Diabetes—Poor HbA1c Control (>9.0%) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recently documented HbA1c level was greater than 9.0 percent. *For this measure, a lower rate indicates better performance.*



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

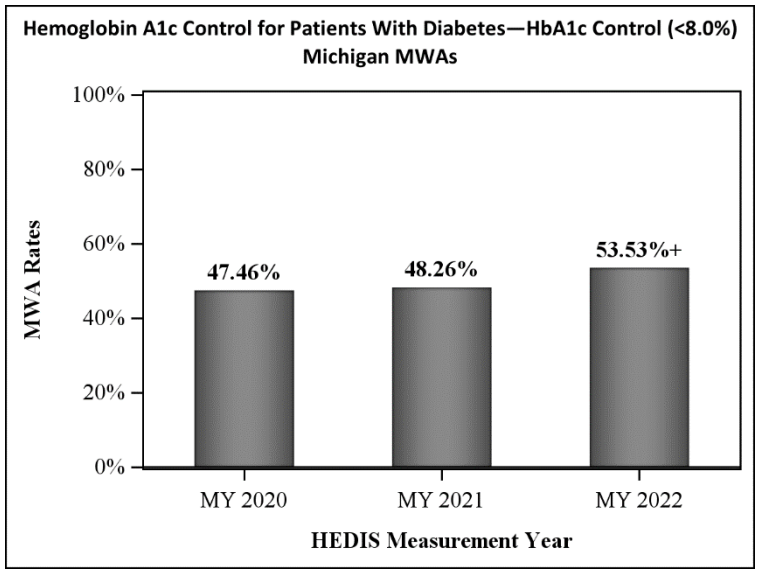
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Two MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 28 percentage points.

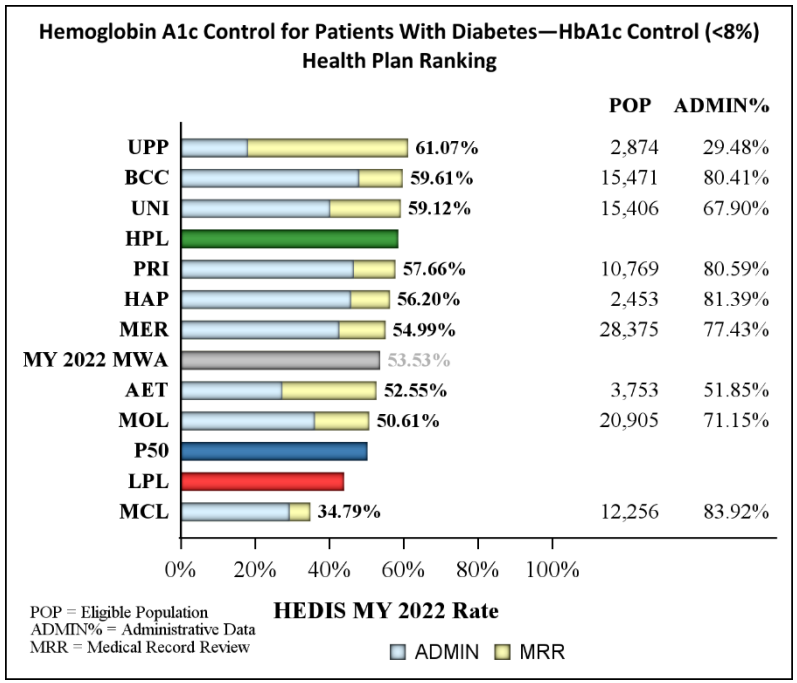
Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)

Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose most recently documented HbA1c level was less than 8.0 percent.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

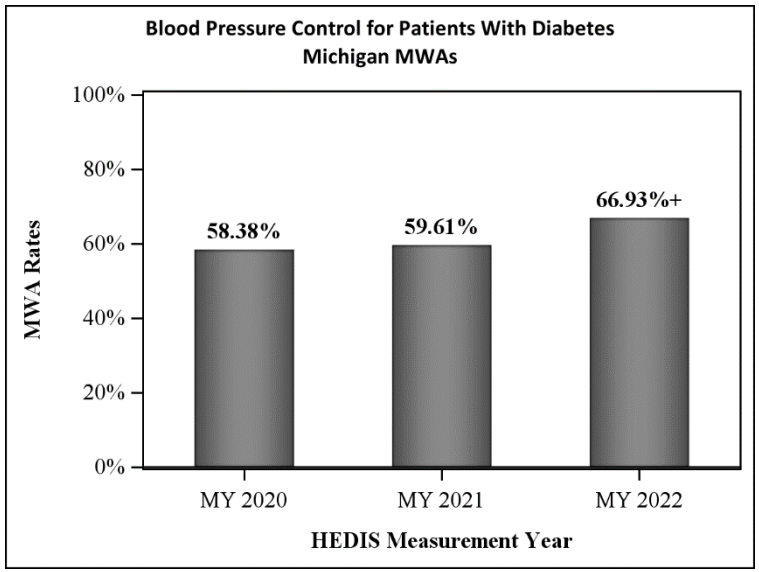
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Three MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP fell below the LPL. MHP performance varied by over 26 percentage points.

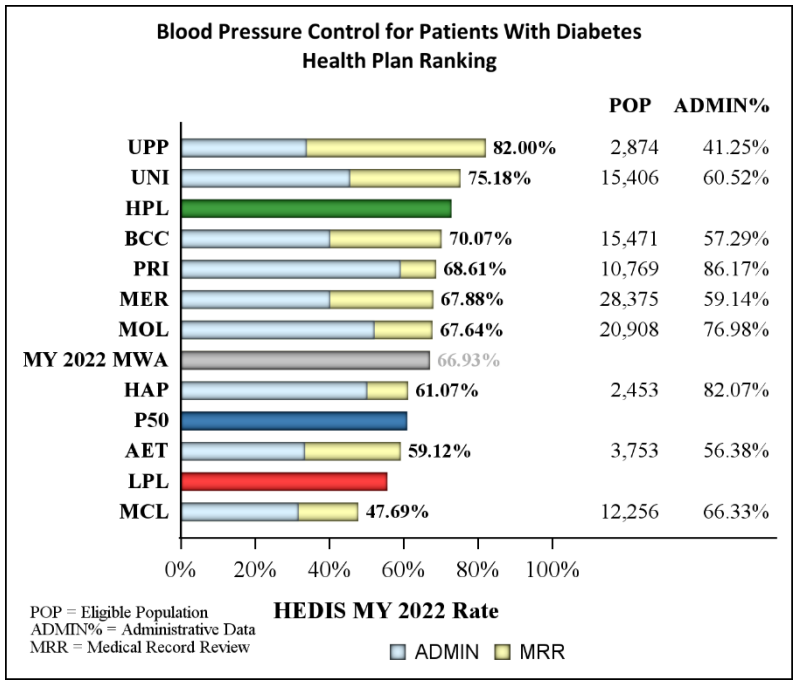
Blood Pressure Control for Patients With Diabetes

Blood Pressure Control for Patients With Diabetes assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and 2) whose blood pressure (BP) was adequately controlled (140/90 mm Hg) during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

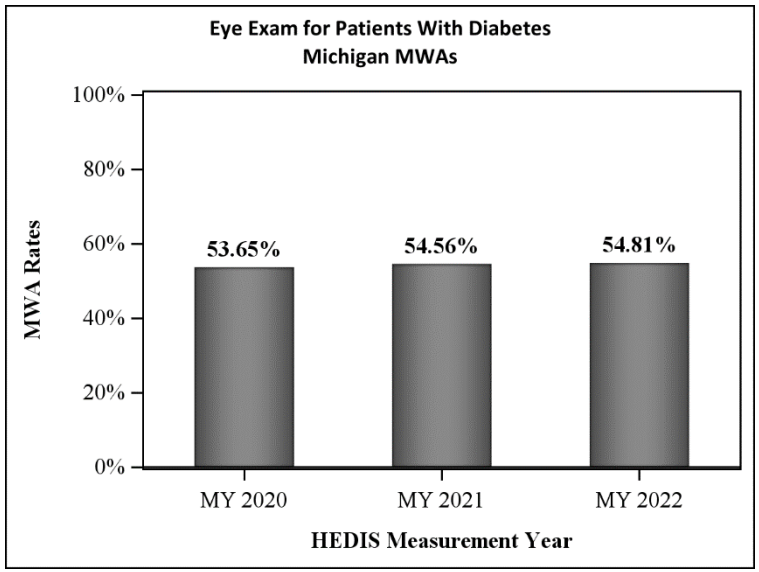
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



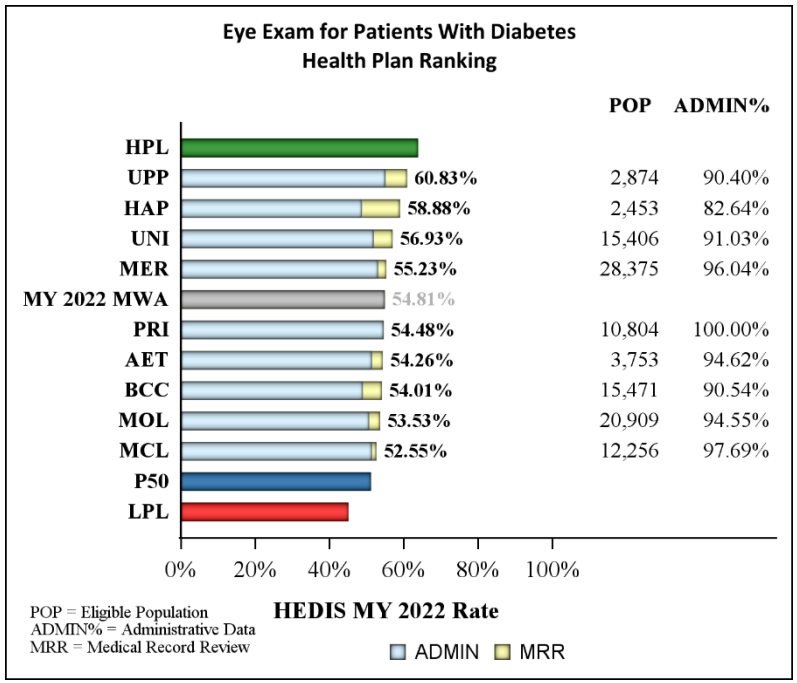
Two MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. One MHP ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 34 percentage points.

Eye Exam for Patients With Diabetes

Eye Exam for Patients With Diabetes assesses the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam.



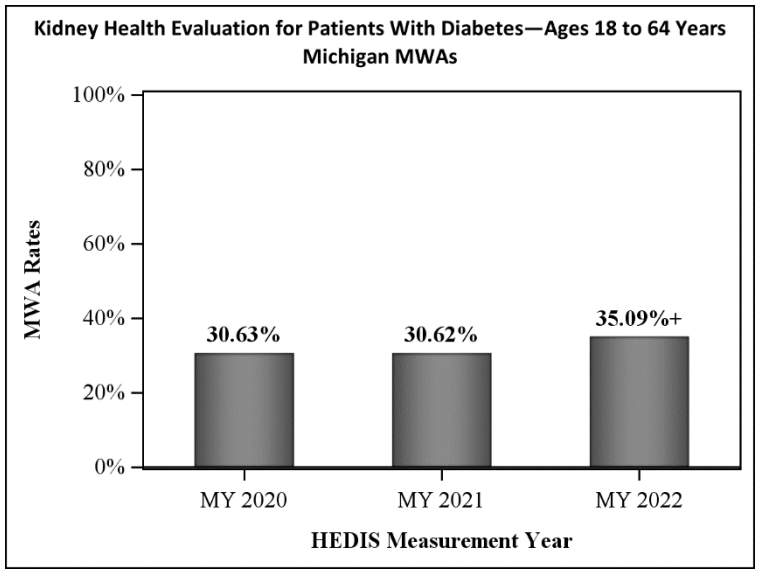
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



Nine MHPs and the MWA ranked above the 50th percentile but fell below the HPL. MHP performance varied by over 8 percentage points.

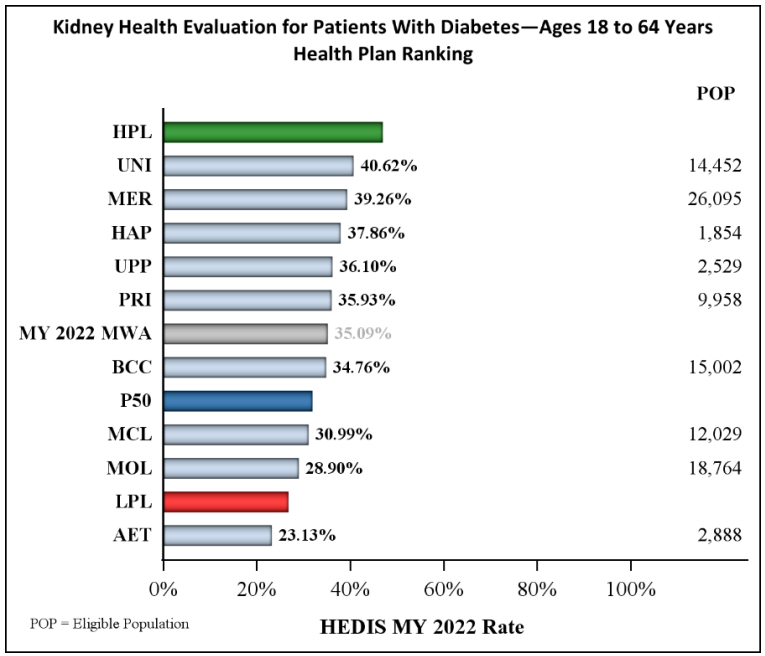
Kidney Health Evaluation for People With Diabetes—Ages 18 to 64 Years

Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years assesses the percentage of members 18 to 64 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

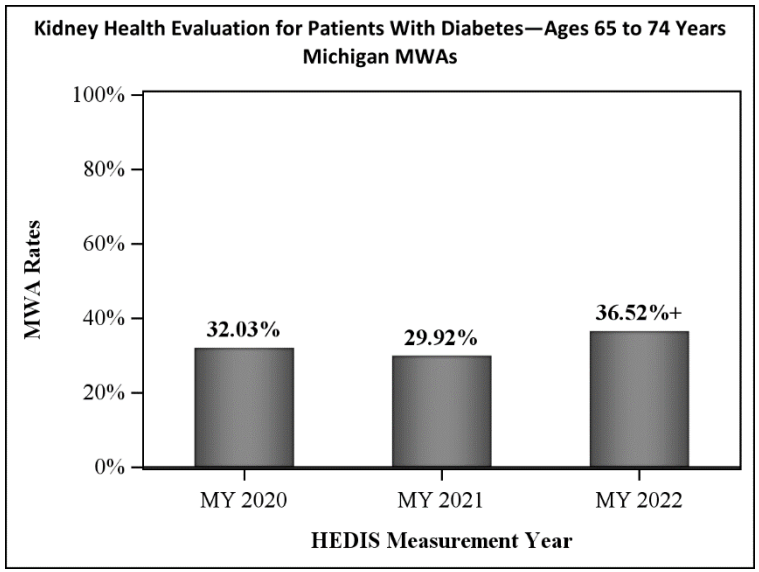
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 17 percentage points.

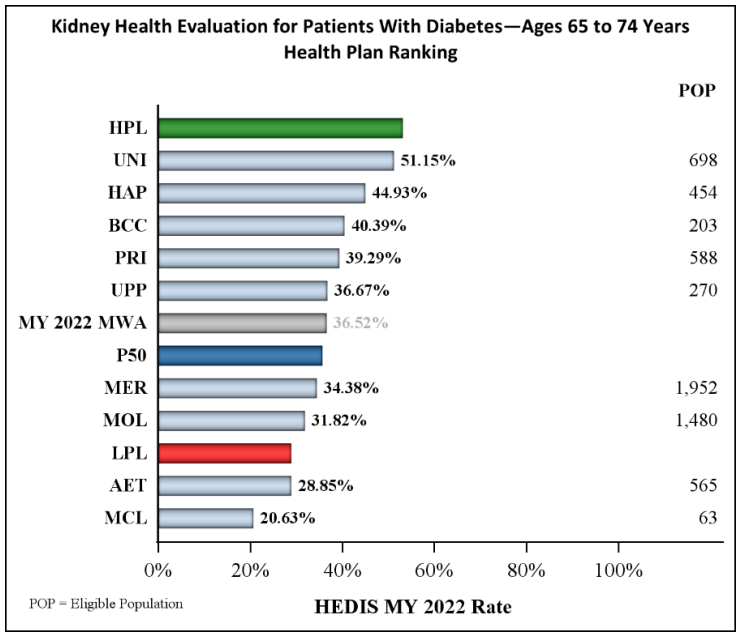
Kidney Health Evaluation for People With Diabetes—Ages 65 to 74 Years

Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years assesses the percentage of members 65 to 74 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an eGFR and an uACR, during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

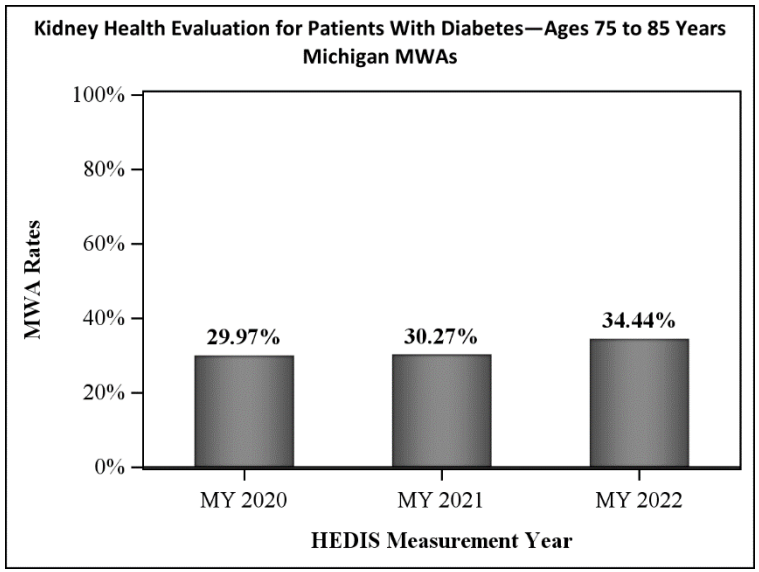
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



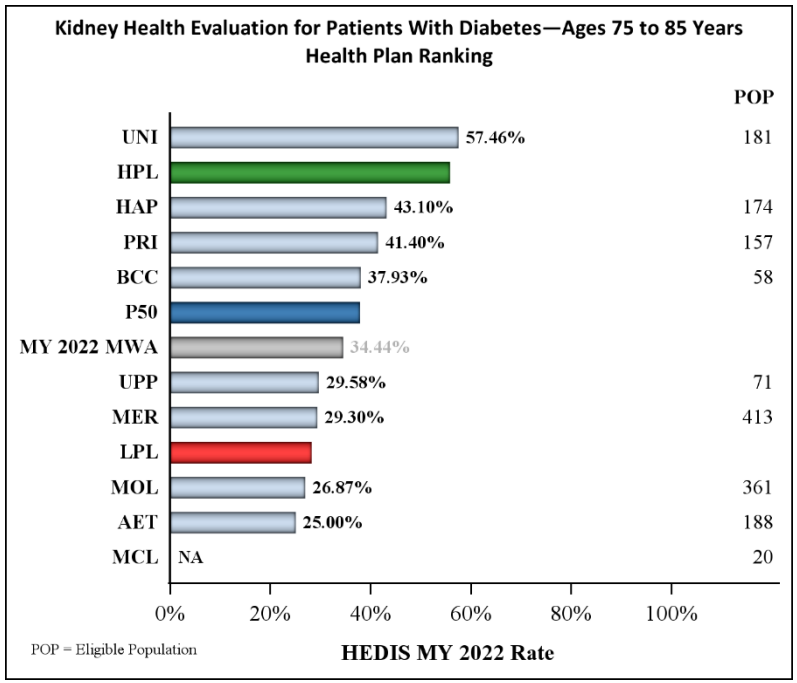
Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 30 percentage points.

Kidney Health Evaluation for People With Diabetes—Ages 75 to 85 Years

Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years assesses the percentage of members 75 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an eGFR and an uACR, during the MY.



The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.

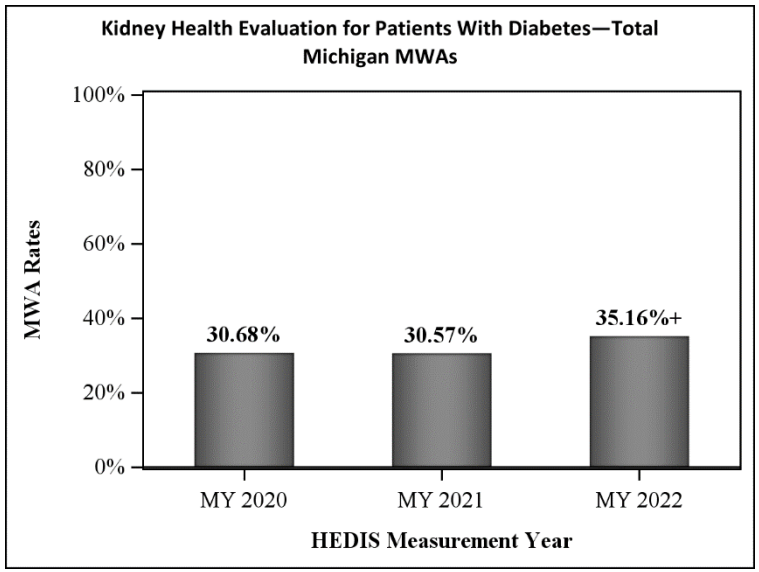


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MHP ranked above the HPL. Three MHPs ranked above the 50th percentile but fell below the HPL. Two MHPs and the MWA ranked above the LPL but fell below the 50th percentile. Two MHPs fell below the LPL. MHP performance varied by over 32 percentage points.

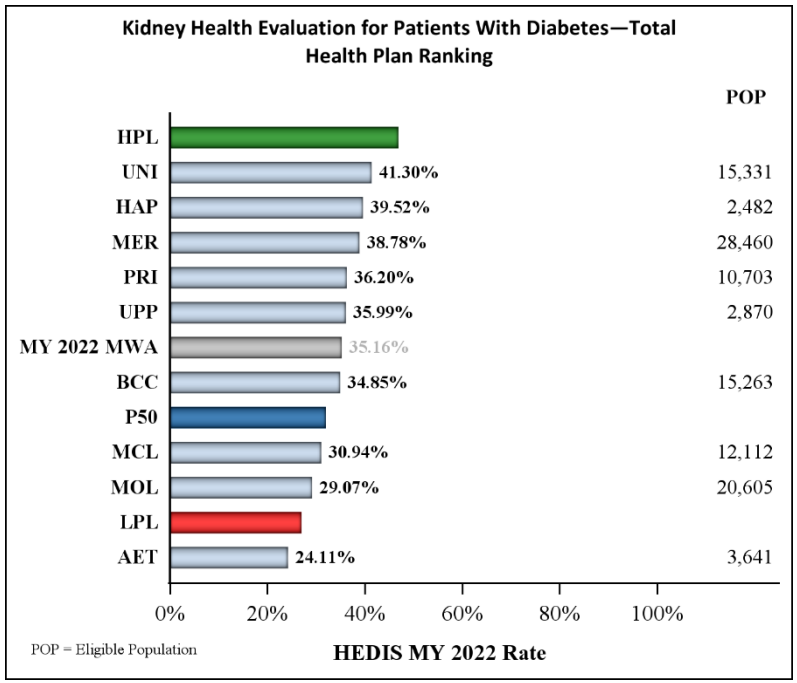
Kidney Health Evaluation for People With Diabetes—Total

Kidney Health Evaluation for Patients With Diabetes—Total assesses the percentage of members 18 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an eGFR and an uACR, during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

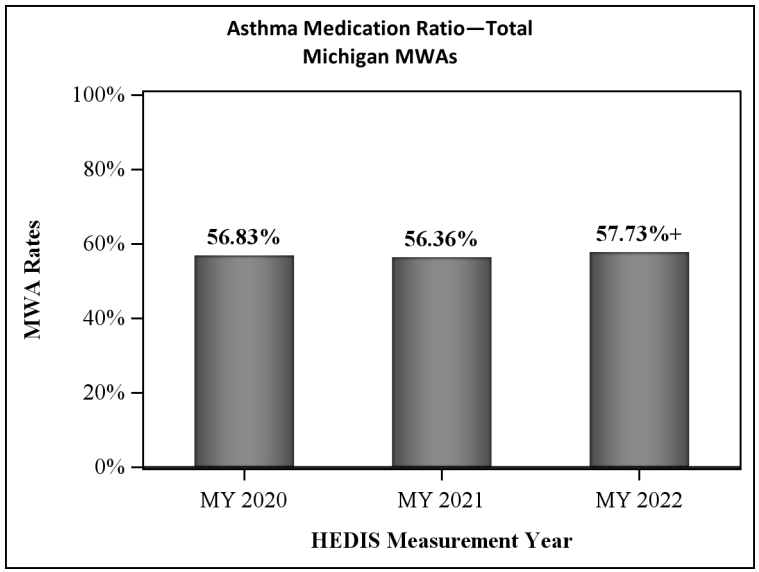
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Six MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 17 percentage points.

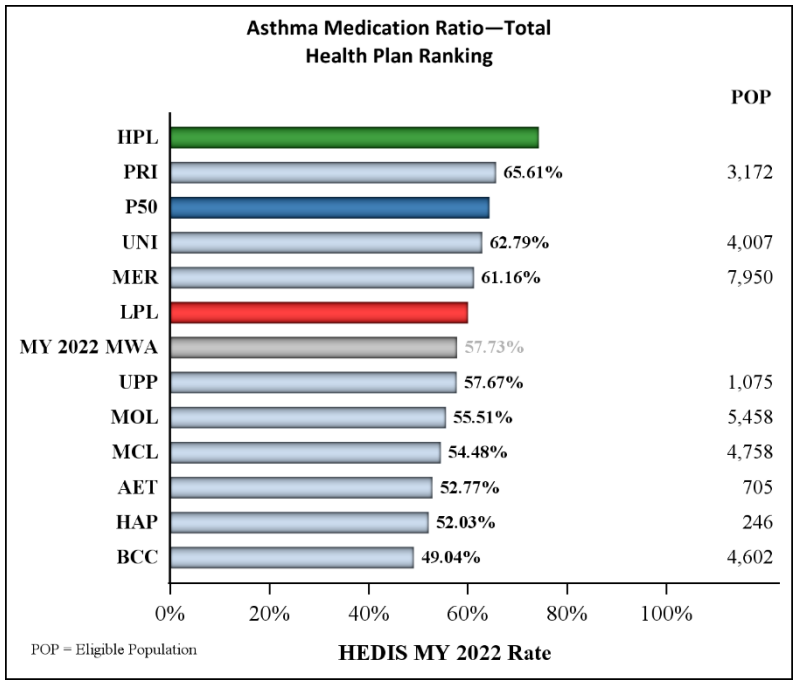
Asthma Medication Ratio—Total

Asthma Medication Ratio—Total assesses the percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

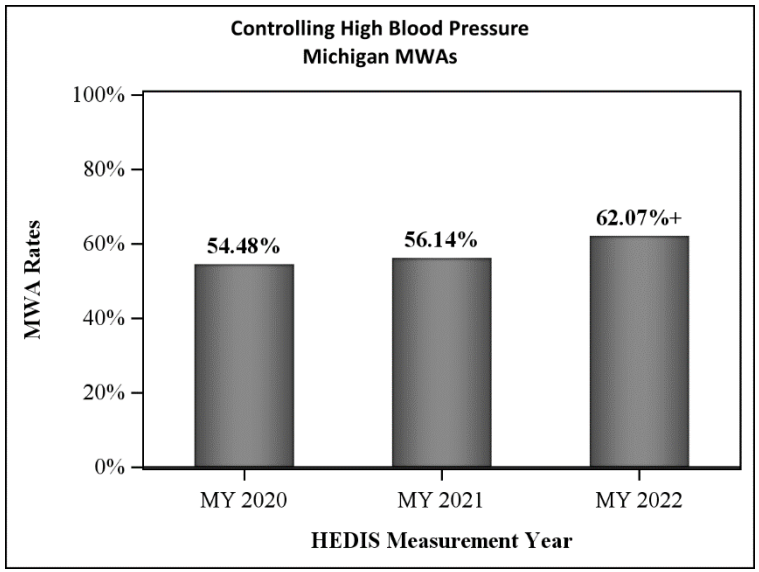
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



One MHP ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. Six MHPs and the MWA fell below the LPL. MHP performance varied by over 16 percentage points.

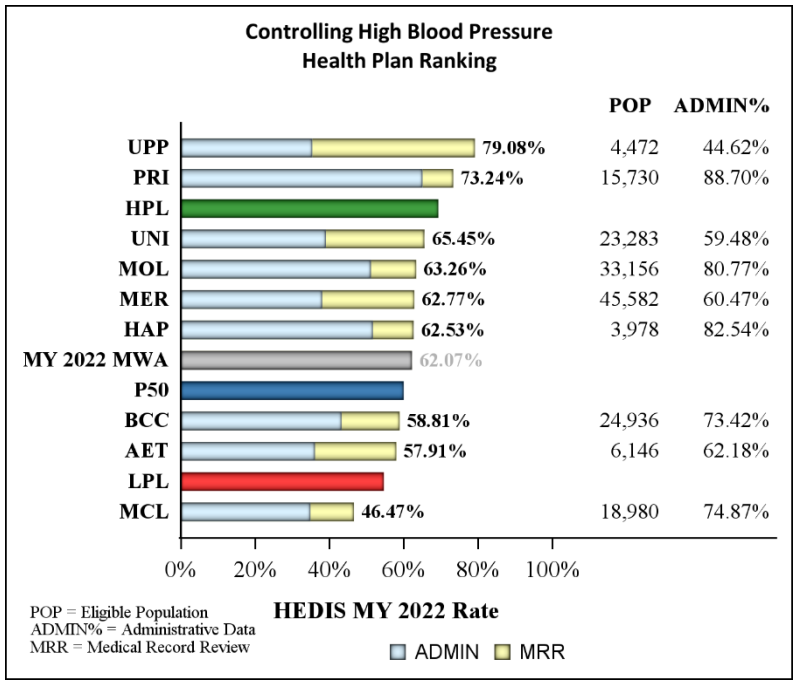
Controlling High Blood Pressure

Controlling High Blood Pressure assesses the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the MY.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

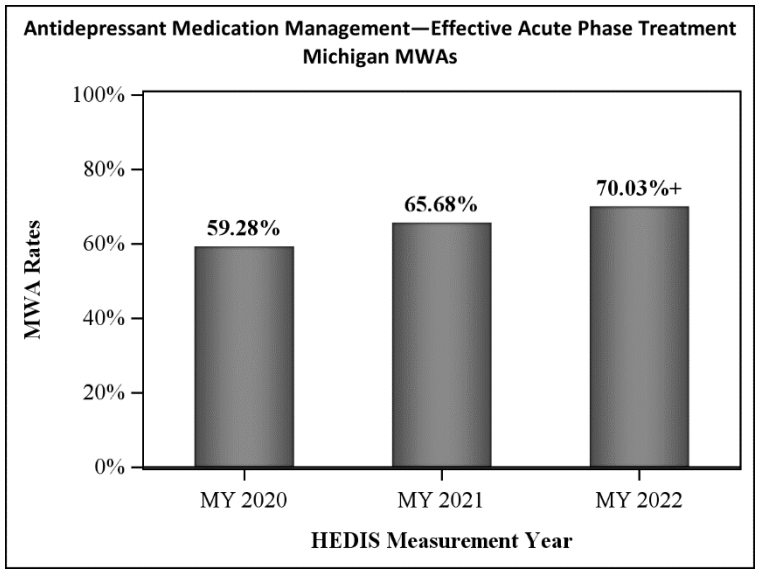
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Two MHPs ranked above the HPL. Four MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Two MHPs ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 32 percentage points.

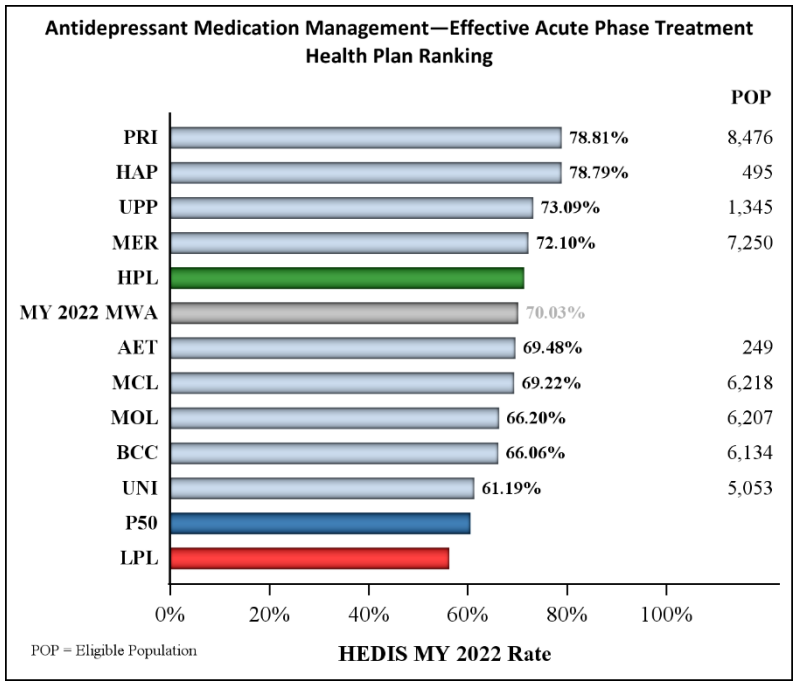
Antidepressant Medication Management—Effective Acute Phase Treatment

Antidepressant Medication Management—Effective Acute Phase Treatment assesses the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment for at least 84 days (12 weeks).



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

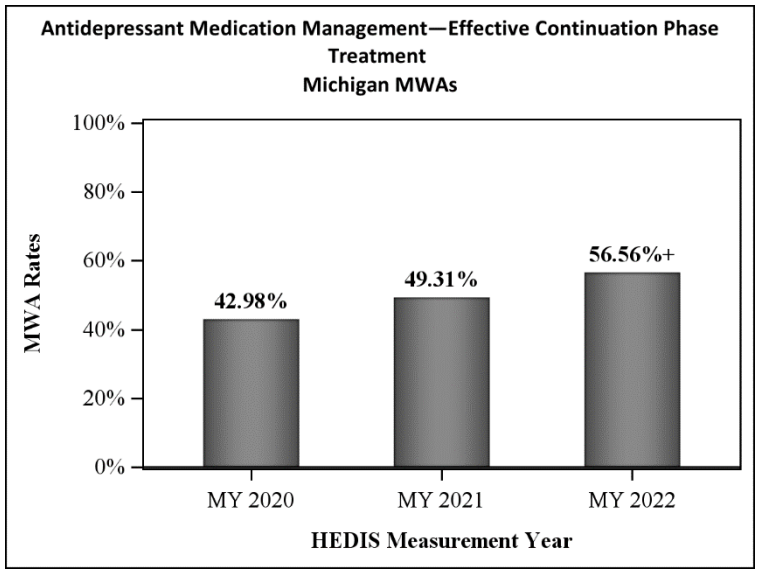
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



Four MHPs ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. MHP performance varied by over 17 percentage points.

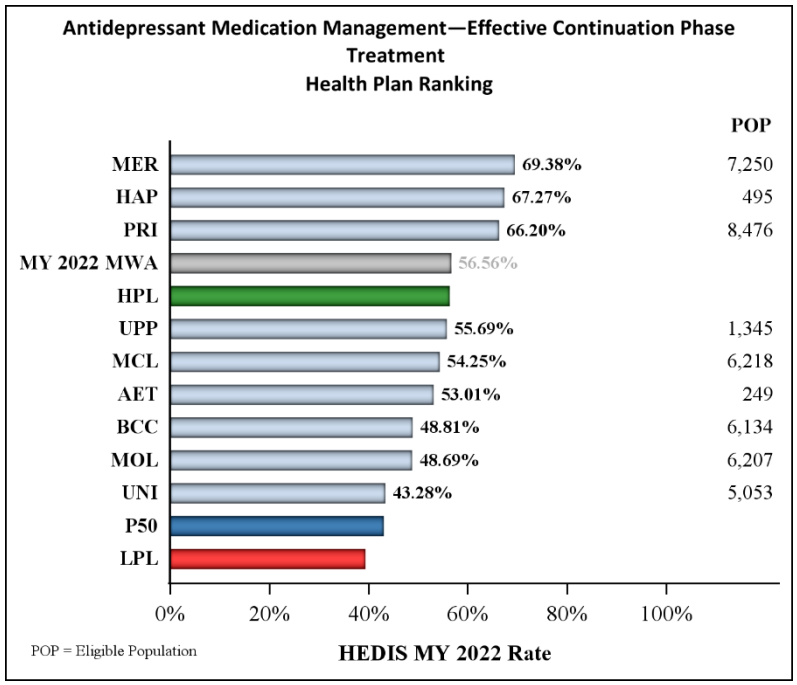
Antidepressant Medication Management—Effective Continuation Phase Treatment

Antidepressant Medication Management—Effective Continuation Phase Treatment assesses the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment for at least 180 days (6 months).



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

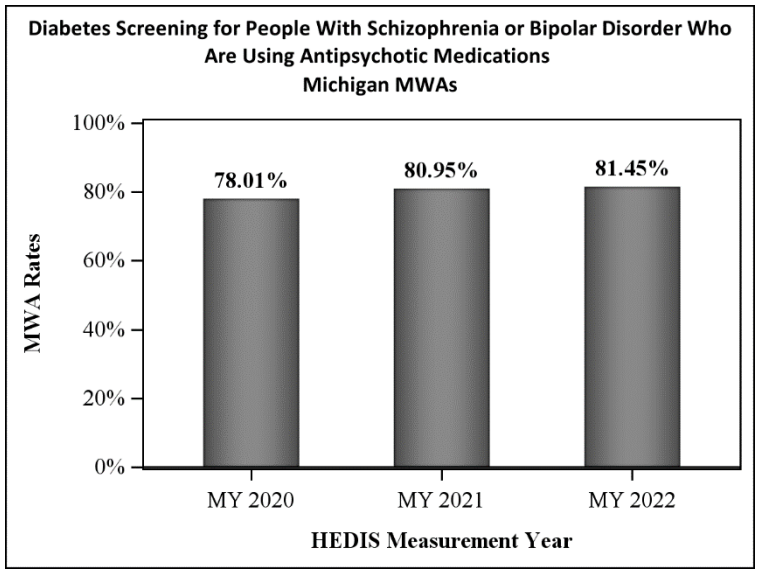
The HEDIS MY 2022 MWA rate significantly improved from HEDIS MY 2021.



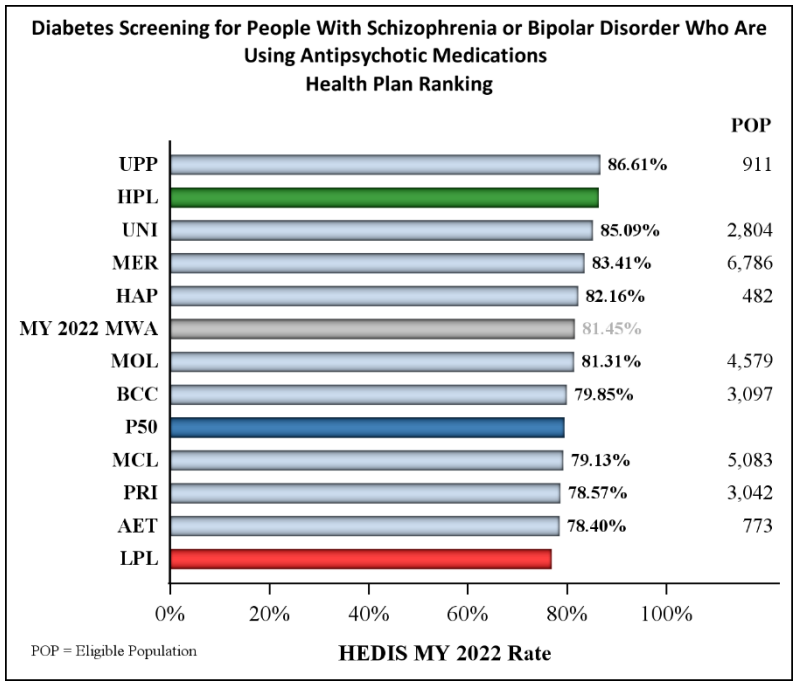
Three MHPs and the MWA ranked above the HPL. Six MHPs ranked above the 50th percentile but fell below the HPL. MHP performance varied by over 26 percentage points.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications assesses the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the MY.



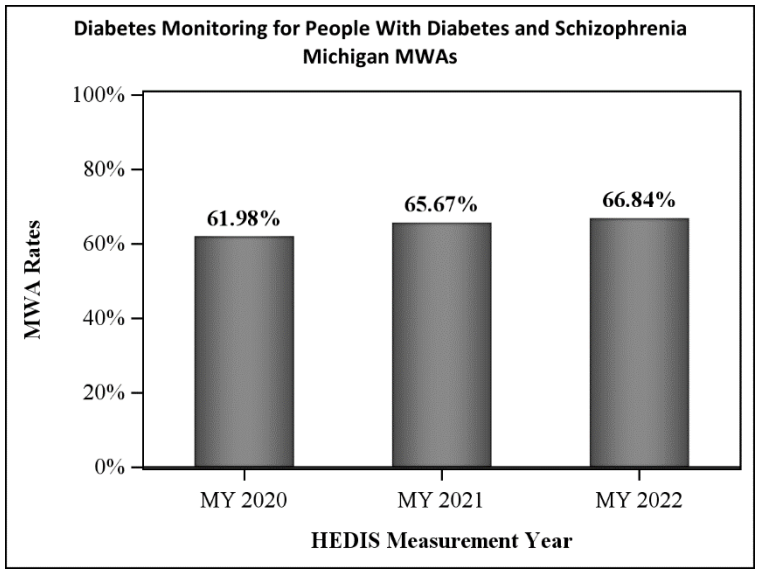
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



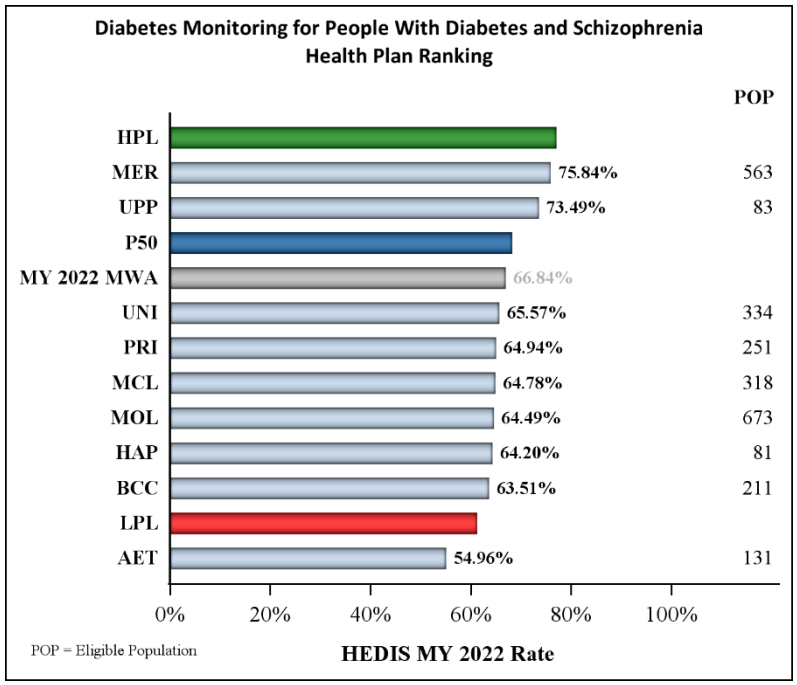
One MHP ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Three MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 8 percentage points.

Diabetes Monitoring for People With Diabetes and Schizophrenia

Diabetes Monitoring for People With Diabetes and Schizophrenia assesses the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and diabetes, who had both a low-density lipoprotein cholesterol (LDL-C) test and an HbA1c test during the MY.



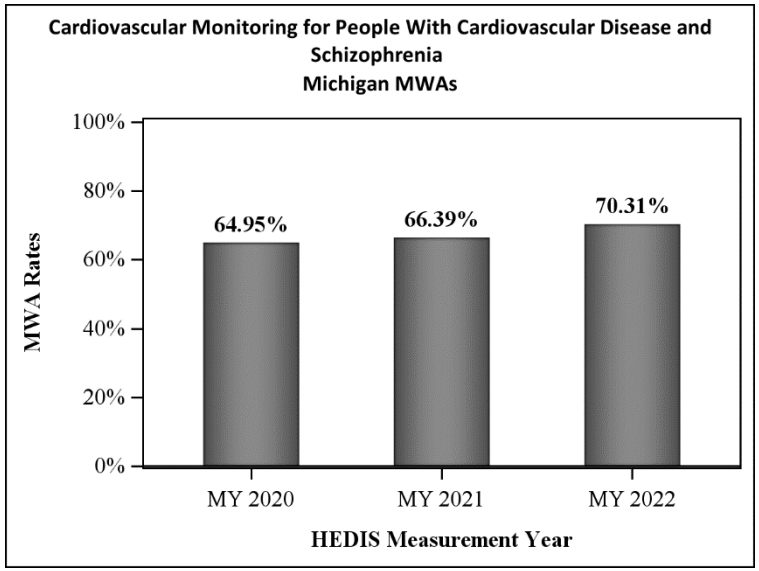
The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



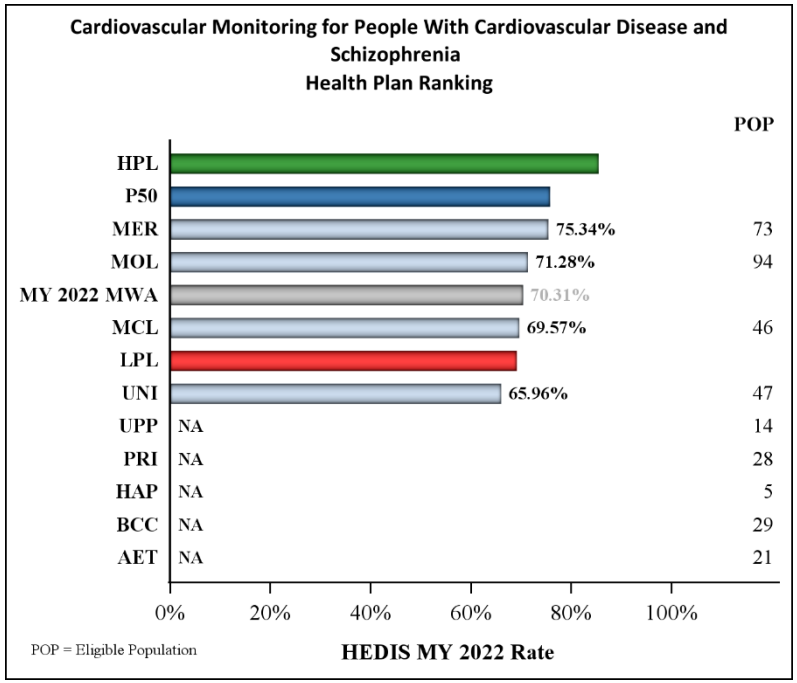
Two MHPs ranked above the 50th percentile but fell below the HPL. Six MHPs and the MWA ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 20 percentage points.

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia assesses the percentage of members 18 to 64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease who had an LDL-C test during the MY.



The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.

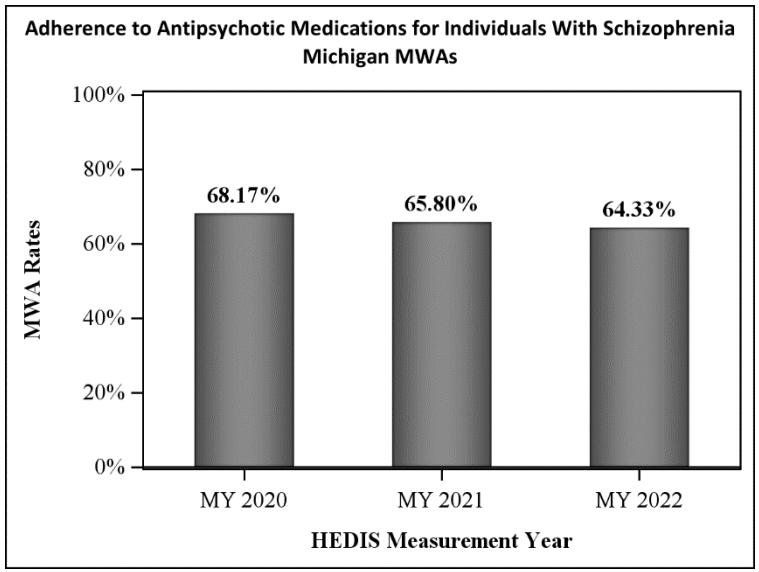


NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

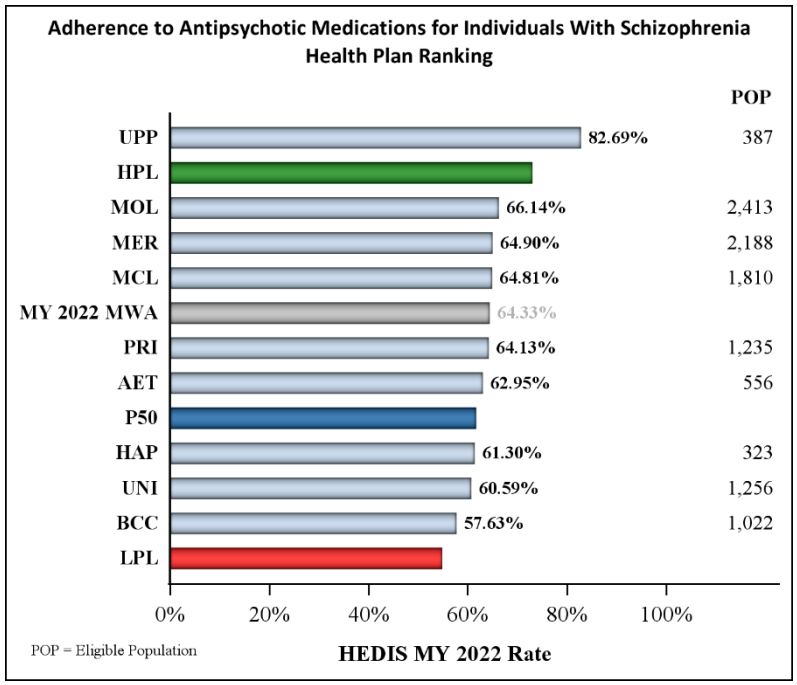
Three MHPs and the MWA ranked above the LPL but fell below the 50th percentile. One MHP fell below the LPL. MHP performance varied by over 9 percentage points.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Adherence to Antipsychotic Medications for Individuals With Schizophrenia assesses the percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.



The HEDIS MY 2022 MWA rate did not demonstrate a significant change from HEDIS MY 2021.



One MHP ranked above the HPL. Five MHPs and the MWA ranked above the 50th percentile but fell below the HPL. Three MHPs ranked above the LPL but fell below the 50th percentile. MHP performance varied by over 25 percentage points.

9. Health Plan Diversity

Introduction

The Health Plan Diversity domain encompasses the following HEDIS measures:

- *Race/Ethnicity Diversity of Membership*
- *Language Diversity of Membership—Spoken Language Preferred for Health Care, Language Preferred for Written Materials,* and *Other Language Needs*

Summary of Findings

Although measures under this domain are not performance measures and are not compared to percentiles, changes observed in the results may provide insight into how select member characteristics affect the MHPs' provision of services and care. The *Race/Ethnicity Diversity of Membership* measure shows that the HEDIS MY 2022 MWA rates for different racial/ethnic groups were fairly stable across years, with less than 4 percentage points difference between MY 2021 and MY 2022 for all racial/ethnic groups.

For the *Language Diversity of Membership* measure, MY 2022 rates remained similar to prior years, with Michigan members reporting English as the preferred spoken language for healthcare and preferred language for written materials, with less than 5 percentage points difference between MY 2021 and MY 2022.

Race/Ethnicity Diversity of Membership

Measure Definition

Race/Ethnicity Diversity of Membership is an unduplicated count and percentage of members enrolled at any time during the MY, by race and ethnicity.

Results

Table 9-1a and b show that the statewide rates for reported racial/ethnic groups remained similar to prior years.

Table 9-1a—MHP and MWA Results for Race/Ethnicity Diversity of Membership

MHP	Eligible Population	White	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian and Other Pacific Islander
AET	70,376	3.70%	3.42%	0.02%	0.08%	0.01%
BCC	364,393	51.82%	35.10%	1.28%	1.97%	2.58%
HAP	49,518	38.26%	42.88%	0.42%	1.30%	0.11%
MCL	289,922	69.28%	21.16%	1.05%	1.08%	0.12%
MER	626,544	61.54%	22.52%	0.86%	1.16%	0.09%
MOL	431,264	41.55%	27.75%	0.33%	0.16%	<0.01%
PRI	290,021	59.70%	25.99%	0.82%	0.94%	0.12%
UNI	333,298	54.52%	30.12%	0.60%	1.76%	0.11%
UPP	66,106	89.89%	1.85%	3.84%	0.51%	0.16%
HEDIS MY 2022 MWA		**55.14%**	**25.81%**	**0.86%**	**1.10%**	**0.44%**
HEDIS MY 2021 MWA		**57.88%**	**28.72%**	**0.88%**	**0.98%**	**0.49%**
HEDIS MY 2020 MWA		**53.44%**	**28.03%**	**0.54%**	**1.61%**	**0.50%**

Table 9-1b—MHP and MWA Results for Race/Ethnicity Diversity of Membership (Continued)

MHP	Eligible Population	Some Other Race	Two or More Races	Unknown	Declined	Hispanic or Latino*
AET	70,376	0.08%	0.00%	92.11%	0.57%	0.09%
BCC	364,393	0.01%	0.02%	7.20%	0.01%	6.07%
HAP	49,518	1.11%	0.00%	15.90%	0.03%	0.50%
MCL	289,922	6.76%	0.00%	0.56%	0.00%	6.32%
MER	626,544	6.06%	<0.01%	7.27%	0.50%	0.01%
MOL	431,264	<0.01%	<0.01%	30.21%	<0.01%	5.03%
PRI	290,021	7.66%	0.00%	4.76%	0.00%	8.37%
UNI	333,298	<0.01%	0.00%	12.90%	0.00%	0.92%
UPP	66,106	3.56%	0.03%	0.00%	0.16%	2.34%
HEDIS MY 2022 MWA		**3.28%**	**<0.01%**	**13.21%**	**0.15%**	**3.63%**
HEDIS MY 2021 MWA		**0.08%**	**<0.01%**	**10.57%**	**0.40%**	**1.76%**
HEDIS MY 2020 MWA		**0.80%**	**<0.01%**	**14.33%**	**0.74%**	**4.47%**

** Starting from HEDIS 2011, the rates associated with members of Hispanic origin were not based on the total number of members in the health plan. Therefore, the rates presented here were calculated by HSAG using the total number of members reported from the Hispanic or Latino column divided by the total number of members in the health plan reported in the MHP IDSS files.*

Language Diversity of Membership

Measure Definition

Language Diversity of Membership is an unduplicated count and percentage of members enrolled at any time during the MY by spoken language preferred for healthcare, the preferred language for written materials, and the preferred language for other language needs.

Results

Table 9-2 shows that the percentage of Michigan members using English as the preferred spoken language for healthcare increased slightly (over 4 percentage points) when compared to MY 2021 but remains the preferred spoken language for healthcare at the statewide level.

Table 9-2—MHP and MWA Results for Language Diversity of Membership—Spoken Language Preferred for Healthcare

MHP	Eligible Population	Declined	English	Non-English	Unknown
AET	70,376	0.00%	0.00%	0.00%	100.00%
BCC	364,393	0.00%	96.48%	3.43%	0.09%
HAP	49,518	0.00%	98.80%	<0.01%	1.20%
MCL	289,922	0.00%	99.08%	0.92%	<0.01%
MER	626,544	0.00%	97.36%	1.57%	1.07%
MOL	431,264	0.00%	98.33%	1.65%	0.02%
PRI	290,021	0.00%	0.00%	0.00%	100.00%
UNI	333,298	0.00%	95.91%	3.92%	0.17%
UPP	66,106	0.00%	99.86%	0.12%	0.02%
HEDIS MY 2022 MWA		**0.00%**	**83.58%**	**1.80%**	**14.62%**
HEDIS MY 2021 MWA		**0.00%**	**78.95%**	**1.23%**	**19.82%**
HEDIS MY 2020 MWA		**0.00%**	**81.23%**	**1.26%**	**17.51%**

Table 9-3 shows that for each MHP, Michigan members who reported a language reported English as the language preferred for written materials. At the statewide level, English remained the preferred language for written materials for most (over 83 percent) Michigan members from MY 2020 to MY 2022.

Table 9-3—MHP and MWA Results for Language Diversity of Membership—Language Preferred for Written Materials

MHP	Eligible Population	English	Non-English	Unknown	Declined
AET	70,376	0.00%	0.00%	100.00%	0.00%
BCC	364,393	96.65%	3.28%	0.07%	0.00%
HAP	49,518	98.80%	<0.01%	1.20%	0.00%
MCL	289,922	98.97%	0.92%	0.11%	0.00%
MER	626,544	97.36%	1.57%	1.07%	0.00%
MOL	431,264	98.33%	1.65%	0.02%	0.00%
PRI	290,021	0.00%	0.00%	100.00%	0.00%
UNI	333,298	95.91%	3.92%	0.17%	0.00%
UPP	66,106	99.86%	0.12%	0.02%	0.00%
HEDIS MY 2022 MWA		**83.59%**	**1.77%**	**14.63%**	**0.00%**
HEDIS MY 2021 MWA		**73.60%**	**1.19%**	**25.21%**	**0.00%**
HEDIS MY 2020 MWA		**75.16%**	**1.22%**	**23.62%**	**0.00%**

Table 9-4 shows that at the statewide level, Michigan members reported English as their preferred language for other language needs, and the Michigan members that listed Unknown as their preferred language for other language needs remained fairly constant from the prior year. Please note that *Language Diversity of Membership—Other Language Needs* captures data collected from questions that cannot be mapped to any other category (e.g., What is the primary language spoken at home?).

Table 9-4—MHP and MWA Results for Language Diversity of Membership—Other Language Needs

MHP	Eligible Population	English	Non-English	Unknown	Declined
AET	70,376	96.25%	1.28%	2.47%	0.00%
BCC	364,393	98.46%	1.53%	0.01%	0.00%
HAP	49,518	98.80%	<0.01%	1.20%	0.00%
MCL	289,922	0.00%	0.00%	100.00%	0.00%
MER	626,544	97.36%	1.57%	1.07%	0.00%
MOL	431,264	98.33%	1.65%	0.02%	0.00%
PRI	290,021	0.00%	0.00%	100.00%	0.00%
UNI	333,298	95.91%	3.92%	0.17%	0.00%
UPP	66,106	0.00%	0.00%	100.00%	0.00%
HEDIS MY 2022 MWA		**72.54%**	**1.45%**	**26.01%**	**0.00%**
HEDIS MY 2021 MWA		**73.38%**	**1.16%**	**25.46%**	**0.00%**
HEDIS MY 2020 MWA		**75.32%**	**1.19%**	**23.50%**	**0.00%**

10. Utilization

Introduction

The Utilization domain encompasses the following HEDIS measures:

- *Ambulatory Care—ED Visits—Total* and *Outpatient Visits—Total*
- *Inpatient Utilization—General Hospital/Acute Care—Discharges—Total Inpatient—Total All Ages, Average Length of Stay—Total Inpatient—Total All Ages, Discharges—Maternity—Total All Ages, Average Length of Stay—Maternity—Total All Ages, Discharges—Surgery—Total All Ages, Average Length of Stay—Surgery—Total All Ages, Discharges—Medicine—Total All Ages, and Average Length of Stay—Medicine—Total All Ages*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*, *Multiple Pharmacies,* and *Multiple Prescribers and Multiple Pharmacies*
- *Use of Opioids at High Dosage*
- *Risk of Continued Opioid Use—At Least 15 Days Covered—Total* and *At Least 31 Days Covered—Total*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*, *Expected Readmissions—Total*, and *O/E Ratio—Total*

The following tables present the HEDIS MY 2022 MHP-specific rates as well as the MWA or MA for HEDIS MY 2022, HEDIS MY 2021, and HEDIS MY 2020, where applicable. To align with calculations from prior years, HSAG calculated traditional averages for the *Ambulatory Care—Total* and *Inpatient Utilization—General Hospital/Acute Care—Total* measure indicators in the Utilization domain; therefore, the MA is presented for those two measures rather than the MWA, which was calculated and presented for all other measures. The *Ambulatory Care* and *Inpatient Utilization* measures are designed to describe the frequency of specific services provided by the MHPs and are not risk adjusted. Therefore, it is important to assess utilization supplemented by information on the characteristics of each MHP's population.

Summary of Findings

Reported rates for the MHPs and MWA rates for the *Ambulatory Care* and *Inpatient Utilization* measures do not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on these measures. For the *Plan All-Cause Readmissions* measure, six MHPs had an O/E ratio less than 1.0, indicating that these MHPs had fewer observed readmissions than were expected based on patient mix. The remaining three MHPs' O/E ratio is more than 1.0 indicating they had more readmissions.

Measure-Specific Findings

Ambulatory Care—Total

The *Ambulatory Care—Total* measure summarizes utilization of ambulatory care for *ED Visits—Total* and *Outpatient Visits—Total*. In this section, the results for the total age group are presented. Of note, while the MHPs' reporting was based on member months during the measurement year, the *ED Visits—Total* and *Outpatient Visits—Total* measure indicator rates are based on per 1,000 member years, in alignment with NCQA's changes to the technical specifications.

Results

Table 10-1 shows *ED Visits—Total* and *Outpatient Visits—Total* per 1,000 member years for ambulatory care for the total age group.

Table 10-1—Ambulatory Care—Total[1] for Total Age Group

MHP	Member Months	ED Visits—Total*	Outpatient Visits Including Telehealth—Total
AET	705,324	712.18	4,199.45
BCC	3,724,000	550.05	4,441.93
HAP	452,343	588.19	4,780.73
MCL	3,048,905	675.09	8,194.31
MER	6,784,695	625.72	4,535.66
MOL	4,581,684	588.66	4,350.58
PRI	2,948,814	621.26	4,752.17
UNI	3,497,734	613.40	4,352.40
UPP	690,373	603.86	3,986.58
HEDIS MY 2022 MA		**613.30**	**4,893.15**
HEDIS MY 2021 MA		**596.47**	**4,974.16**
HEDIS MY 2020 MA		**577.20**	**4,337.52**

** Awareness is advised when interpreting results for this indicator as a lower rate is a higher percentile.*

[1] Due to changes in the technical specifications for this measure, NCQA noted for the Medicaid product line that organizations that want to trend data to MY 2022 may multiply rates prior to MY 2022 by 12.

For the *ED Visits—Total* measure indicator, the MA increased by 36.1 visits per 1,000 member years from HEDIS MY 2020 to HEDIS MY 2022. The MA for the *Outpatient Visits—Total* measure indicator increased from HEDIS MY 2020 to HEDIS MY 2022 by 555.63 visits per 1,000 member years.

Inpatient Utilization—General Hospital/Acute Care—Total

The *Inpatient Utilization—General Hospital/Acute Care—Total* measure summarizes utilization of acute inpatient care and services in four categories: *Total Inpatient*, *Maternity, Surgery,* and *Medicine*. Of note, while the MHPs' reporting was based on member months during the measurement year, the *Total Discharges* measure indicator rates are based on per 1,000 member years, in alignment with NCQA's changes to the technical specifications.

Results

Table 10-2 shows the member months for all ages and the *Total Discharges* per 1,000 member years for the total age group. The values in the table below are presented for information only.

Table 10-2—Inpatient Utilization[1]—General Hospital/Acute Care: Total Discharges for Total Age Group

MHP	Member Months	Total Inpatient	Maternity*	Surgery	Medicine
AET	705,324	84.57	21.08	23.33	45.48
BCC	3,724,000	70.93	23.94	17.35	34.83
HAP	452,343	104.55	22.58	28.41	58.52
MCL	3,048,905	77.31	24.60	19.51	38.65
MER	6,784,695	70.50	23.73	13.14	39.75
MOL	4,581,684	65.87	25.25	14.50	32.52
PRI	2,948,814	58.89	24.48	13.82	26.77
UNI	3,497,734	57.21	21.89	13.76	26.73
UPP	690,373	66.38	19.11	19.36	32.61
HEDIS MY 2022 MA		**68.34**	**23.75**	**15.56**	**34.79**
HEDIS MY 2021 MA		**76.31**	**25.59**	**17.69**	**39.41**
HEDIS MY 2020 MA		**87.72**	**28.20**	**20.64**	**46.20**

** The Maternity measure indicators were calculated using member months for members 10 to 64 years of age.*

[1] Due to changes in the technical specifications for this measure, NCQA noted for the Medicaid product line that organizations that want to trend data to MY 2022 may multiply rates prior to MY 2022 by 12.

Table 10-3 displays the *Total Average Length of Stay* for all ages. The values in the table are presented for information only.

Table 10-3—Inpatient Utilization[1]—General Hospital/Acute Care: Total Average Length of Stay for Total Age Group

MHP	Member Months	Total Inpatient	Maternity	Surgery	Medicine
AET	705,324	6.14	2.44	9.51	5.70
BCC	3,724,000	4.92	2.87	8.19	4.40
HAP	452,343	5.77	2.48	9.55	4.92
MCL	3,048,905	4.27	1.67	6.86	4.26
MER	6,784,695	4.96	2.71	7.96	4.96
MOL	4,581,684	5.15	2.91	9.84	4.35
PRI	2,948,814	5.01	2.85	8.53	4.68
UNI	3,497,734	5.30	2.43	9.30	5.04
UPP	690,373	4.96	2.54	7.56	4.48
HEDIS MY 2022 MA		**5.00**	**2.61**	**8.45**	**4.69**
HEDIS MY 2021 MA		**4.83**	**2.61**	**8.16**	**4.41**
HEDIS MY 2020 MA		**4.65**	**2.49**	**7.62**	**4.33**

[1] *Due to changes in the technical specifications for this measure, NCQA noted for the Medicaid product line that organizations that want to trend data to MY 2022 may multiply rates prior to MY 2022 by 12.*

Use of Opioids From Multiple Providers

The *Use of Opioids From Multiple Providers* summarizes the proportion of members 18 years of age and older, receiving prescription opioids for ≥15 days during the MY, who received opioids from multiple providers. Three rates are reported: *Multiple Prescribers*, *Multiple Pharmacies*, and *Multiple Prescribers and Multiple Pharmacies.*

Results

Table 10-4 shows the HEDIS MY 2022 rates for receiving prescription opioids. The values in the table below are presented for information only.

Table 10-4—Use of Opioids From Multiple Providers*

MHP	Use of Opioids From Multiple Providers—Eligible Population	Use of Opioids From Multiple Providers—Multiple Prescribers	Use of Opioids From Multiple Providers—Multiple Pharmacies	Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies
AET	2,301	16.38%	3.26%	2.43%
BCC	8,713	17.25%	2.42%	1.63%
HAP	1,429	16.79%	2.73%	1.82%
MCL	8,113	14.32%	1.74%	0.91%
MER	21,981	13.18%	3.37%	1.55%
MOL	13,246	14.44%	1.98%	1.34%
PRI	6,658	18.94%	1.68%	0.99%
UNI	8,646	15.70%	1.64%	1.11%
UPP	2,260	17.04%	6.19%	4.03%
HEDIS MY 2022 MWA		**15.13%**	**2.54%**	**1.46%**
HEDIS MY 2021 MWA		**15.03%**	**2.32%**	**1.52%**
HEDIS MY 2020 MWA		**14.60%**	**3.03%**	**1.88%**

**For this measure, a lower rate indicates better performance.*

Use of Opioids at High Dosage

The *Use of Opioids at High Dosage* summarizes the proportion of members 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the MY.

Results

Table 10-5 shows the HEDIS MY 2022 rates for members receiving prescription opioids at a high dosage. The values in the table below are presented for information only.

Table 10-5—Use of Opioids at High Dosage*

MHP	Eligible Population	Rate
AET	1,956	2.81%
BCC	7,790	0.80%
HAP	1,179	1.27%
MCL	7,133	1.33%
MER	19,875	1.56%
MOL	11,798	1.40%
PRI	5,906	1.71%
UNI	7,656	1.95%
UPP	1,984	2.42%
HEDIS MY 2022 MWA		**1.53%**
HEDIS MY 2021 MWA		**3.98%**
HEDIS MY 2020 MWA		**2.86%**

** For this measure, a lower rate indicates better performance.*

Risk of Continued Opioid Use

The *Risk of Continued Opioid Use* summarizes new episodes of opioid use that put members 18 years of age and older at risk for continued opioid use.

Results

Table 10-6 shows the HEDIS MY 2022 rates for members whose new episode lasted at least 15 days in a 30-day period and at least 31 days in a 62-day period. The values in the table below are presented for information only.

Table 10-6—Risk of Continued Opioid Use*

MHP	Eligible Population	At Least 15 Days Covered—Total	At Least 31 Days Covered—Total
AET	3,445	9.81%	7.14%
BCC	18,489	7.56%	5.37%
HAP	2,117	11.71%	5.53%
MCL	15,206	6.41%	4.60%
MER	32,056	16.04%	9.27%
MOL	21,330	11.66%	5.97%
PRI	12,178	13.11%	6.66%
UNI	15,497	8.96%	6.27%
UPP	3,730	7.64%	4.91%
HEDIS MY 2022 MWA		**11.17%**	**6.66%**
HEDIS MY 2021 MWA		**10.78%**	**7.10%**
HEDIS MY 2020 MWA		**10.66%**	**6.72%**

** For this measure, a lower rate indicates better performance.*

Plan All-Cause Readmissions

The *Plan All-Cause Readmissions* measure summarizes the percentage of inpatient hospital admissions for members 18 years of age and older that result in an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. This measure is risk-adjusted, so an O/E ratio is also calculated that indicates whether an MHP had more readmissions (O/E ratio greater than 1.0) or fewer readmissions (O/E ratio less than 1.0) than expected based on population mix.

Results

Table 10-7 shows the HEDIS MY 2022 observed rates, expected rates, and the O/E ratio for inpatient hospital admissions that were followed by an unplanned readmission for any diagnosis within 30 days.

Table 10-7—Plan All-Cause Readmissions*

MHP	Index Admissions	Observed Readmissions—Total	Expected Readmissions—Total	O/E Ratio—Total
AET	1,314	13.85%	10.73%	1.2912
BCC	8,064	10.65%	10.25%	1.0390
HAP	917	8.83%	10.44%	0.8463
MCL	10,989	9.56%	9.63%	0.9936
MER	14,338	10.85%	10.47%	1.0361
MOL	14,438	8.82%	9.65%	0.9145
PRI	7,267	8.61%	9.64%	0.8936
UNI	5,603	10.49%	10.88%	0.9645
UPP	1,417	7.69%	9.82%	0.7834
HEDIS MY 2022 MWA		**9.83%**	**10.05%**	**0.9784**
HEDIS MY 2021 MWA		**9.21%**	**9.81%**	**0.9386**
HEDIS MY 2020 MWA		**9.65%**	**9.90%**	**0.9752**

** For this measure, a lower rate indicates better performance.*

The rates of observed readmissions ranged from 7.69 percent for Upper Peninsula to 13.85 percent for Aetna; however, three of the nine MHPs had an O/E ratio greater than 1.0, indicating that these MHPs had more readmissions. The remaining six MHPs had an O/E ratio less than 1.0, indicating that these MHPs had fewer observed readmissions than were expected based on patient mix.

HEDIS Reporting Capabilities—Information Systems Findings

NCQA's IS standards are the guidelines used by certified HEDIS compliance auditors to assess an MHP's ability to report HEDIS data accurately and reliably.[11-1] Compliance with the guidelines also helps an auditor to understand an MHP's HEDIS reporting capabilities. For HEDIS MY 2022, MHPs were assessed on six IS standards. To assess an MHP's adherence to the IS standards, HSAG reviewed several documents for the MHPs. These included the MHPs' final audit reports (FARs), IS compliance tools, and the IDSS files approved by their respective NCQA-licensed audit organization (LO).

All nine of the Michigan MHPs that underwent NCQA HEDIS Compliance Audits in Michigan in 2022 contracted with the same LOs in 2023. The MHPs were able to select the LO of their choice. Overall, the Michigan MHPs consistently maintain the same LOs across reporting years.

For HEDIS MY 2022, all MHPs contracted with external software vendors for HEDIS measure production and rate calculation. HSAG reviewed the MHPs' FARs and ensured that these software vendors participated in and passed the NCQA Measure Certification[SM] process.[11-2] MHPs could purchase the software with certified measures and generate HEDIS measure results internally or provide all data to the software vendor to generate HEDIS measures for them. Either way, using software with NCQA-certified measures may reduce the MHPs' burden for reporting and help ensure rate validity. For the MHP that calculated its rate using internally developed source code, the auditor selected a core set of measures and manually reviewed the programming codes to verify accuracy and compliance with HEDIS MY 2022 technical specifications.

HSAG found that, in general, all MHPs' IS and processes were compliant with the applicable IS standards and the HEDIS determination reporting requirements related to the measures for HEDIS MY 2022. The following sections present NCQA's IS standards and summarize the audit findings related to each IS standard for the MHPs.

11-1 National Committee for Quality Assurance. *HEDIS® MY 2022, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*. Washington D.C.

11-2 NCQA Measure Certification[SM] is a service mark of the NCQA.

IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry

This standard assesses whether:

- Industry standard codes are used and all characters are captured.
- Principal codes are identified and secondary codes are captured.
- Nonstandard coding schemes are fully documented and mapped back to industry standard codes.
- Standard submission forms are used and capture all fields relevant to measure reporting; all proprietary forms capture equivalent data; and electronic transmission procedures conform to industry standards.
- Data entry and file processing procedures are timely and accurate and include sufficient edit checks to ensure the accurate entry and processing of submitted data in transaction files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 1.0, Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry*. The auditors confirmed that the MHPs captured all necessary data elements appropriately for HEDIS reporting. A majority of the MHPs accepted industry standard codes on industry standard forms. Any nonstandard code that was used for measure reporting was mapped to industry standard code appropriately. Adequate validation processes such as built-in edit checks, data monitoring, and quality control audits were in place to ensure that only complete and accurate claims and encounter data were used for HEDIS reporting.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- The organization has procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of membership data have necessary procedures to ensure accuracy.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 2.0, Enrollment Data—Data Capture, Transfer, and Entry*. Data fields required for HEDIS measure reporting were captured appropriately. Based on the auditors' review, all MHPs processed eligibility files in a timely manner. Enrollment information housed in the MHPs' systems was reconciled against the enrollment files provided by the State. Sufficient data validations were in place to ensure that only accurate data were used for HEDIS reporting.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- Provider specialties are fully documented and mapped to HEDIS provider specialties necessary for measure reporting.
- The organization has effective procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of practitioner data are checked to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 3.0, Practitioner Data—Data Capture, Transfer, and Entry.* MHPs had sufficient processes in place to capture all data elements required for HEDIS reporting. Primary care practitioners and specialists were appropriately identified by all MHPs. Provider specialties were fully and accurately mapped to HEDIS-specified provider types. Adequate validation processes were in place to ensure that only accurate provider data were used for HEDIS reporting.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

This standard assesses whether:

- Forms capture all fields relevant to measure reporting and whether electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).
- Retrieval and abstraction of data from medical records are reliably and accurately performed.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 4.0, Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight*. Medical record data were used by all MHPs to report HEDIS hybrid measures. Medical record abstraction tools were reviewed and approved by the MHPs' auditors for HEDIS reporting. Contracted vendor staff or internal staff used by the MHPs had sufficient qualification and training in the current year's HEDIS technical specifications and the use of MHP-specific abstraction tools to accurately conduct medical record reviews. Sufficient validation processes and edit checks were in place to ensure data completeness and data accuracy.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- The organization has effective procedures for submitting measure-relevant information for data entry and whether electronic transmissions of data have validation procedures to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.
- Data approved for electronic clinical data system (ECDS) reporting met reporting requirements.

All MHPs were fully compliant with *IS 5.0, Supplemental Data—Capture, Transfer, and Entry*. Supplemental data sources used by the MHPs were verified and approved by the auditors. The auditors performed primary source verification of a sample of records selected from each nonstandard supplemental database used by the MHPs. In addition, the auditors reviewed the supplemental data impact reports provided by the MHPs for reasonability. Validation processes such as reconciliation between original data sources and MHP-specific data systems, edit checks, and system validations ensured data completeness and data accuracy. There were no issues noted regarding how the MHPs managed the collection, validation, and integration of the various supplemental data sources. The auditors continued to encourage the MHPs to explore ways to maximize the use of supplemental data.

IS 6.0—Data Production Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.
- Data transfers to HEDIS repository from transaction files are accurate.
- File consolidations, extracts, and derivations are accurate.
- Repository structure and formatting is suitable for measures and enable required programming efforts.
- Report production is managed effectively and operators perform appropriately.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 6.0—Data Production Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity*.

All but two MHPs contracted with external software vendors for HEDIS measure production and rate calculation. Measures were benchmarked to assess potential for bias. Cross measure checks were performed to determine appropriate relationships exist. Confirmed data logic for code mapping was applied consistently. When non-standard coding schemes were used, mapping documents showed that code systems were identified and mapped according to the requirements in the specifications. Data source identifiers were clear and documented.

IS 7.0—Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

This standard assesses whether:

- Data transfers to the HEDIS measure vendor from the HEDIS repository are accurate.
- Report production is managed effectively and operators perform appropriately.
- Measure reporting software is managed properly with regard to development, methodology, documentation, revision control, and testing.
- The organization regularly monitors vendor performance against expected performance standards.

All MHPs were fully compliant with *IS 7.0, Data Integration and Reporting—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity.* For the MHP that did not use a software vendor, the auditor requested, reviewed, and approved source code for a selected core set of HEDIS measures. For all MHPs, the auditors determined that data mapping, data transfers, and file consolidations were sufficient. Adequate validation processes were in place for all MHPs to ensure that only accurate and complete data were used for HEDIS reporting. The auditors did not document any issues with the MHPs' data integration and report production processes. Sufficient vendor oversight was in place for each MHP using a software vendor.

Glossary

Table 12-1 provides definitions of terms and acronyms used throughout this report.

Table 12-1—Definition of Terms

Term	Description
ADHD	Attention-deficit/hyperactivity disorder.
Audit Result	The HEDIS auditor's final determination, based on audit findings, of the appropriateness of the MHP to publicly report its HEDIS measure rates. Each measure indicator rate included in the HEDIS audit receives an audit result of *Reportable (R)*, *Small Denominator (NA)*, *Biased Rate (BR), No Benefit (NB), Not Required (NQ), Not Reported (NR),* and *Un-Audited (UN)*.
ADMIN%	Percentage of the rate derived using administrative data (e.g., claims data and immunization registry).
BMI	Body mass index.
BR	Biased Rate; indicates that the MHP's reported rate was invalid; therefore, the rate was not presented.
CDC	Centers for Disease Control and Prevention.
COVID-19	Coronavirus disease 2019.
Data Completeness	The degree to which occurring services/diagnoses appear in the MHP's administrative data systems.
Denominator	The number of members who meet all criteria specified in a measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.
DTaP	Diphtheria, tetanus, and acellular pertussis vaccine.
ECDS	Electronic clinical data system. A structured, electronic version of a patient's comprehensive medical experiences maintained over time that may include some or all key administrative clinical data relevant to care (e.g., demographics, progress notes, problems, medications, vital signs, past medical history, social history, immunizations, laboratory data, radiology reports).
ED	Emergency department.
EDI	Electronic data interchange; the direct computer-to-computer transfer of data.
eGFR	Estimated glomerular filtration rate.

Term	Description
Encounter Data	Billing data received from a capitated provider. (Although the MHP does not reimburse the provider for each encounter, submission of encounter data allows the MHP to collect the data for future HEDIS reporting.)
FAR	Following the MHP's completion of any corrective actions, an auditor completes the final audit report (FAR), documenting all final findings and results of the HEDIS audit. The FAR includes a summary report, IS capabilities assessment, medical record review validation findings, measure results, and the auditor's audit opinion (the final audit statement).
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.
HEDIS Repository	The data warehouse where all data used for HEDIS reporting are stored.
HepA	Hepatitis A vaccine.
HepB	Hepatitis B vaccine.
HiB Vaccine	Haemophilus influenza type B vaccine.
HMO	Health maintenance organization.
HPL	High performance level. (For most performance measures, MDHHS defined the HPL as the most recent national Medicaid 90th percentile. For measures such as *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]*, in which lower rates indicate better performance, the 10th percentile [rather than the 90th percentile] is considered the HPL.)
HPV	Human papillomavirus.
hrHPV	High-risk human papillomavirus.
HSAG	Health Services Advisory Group, Inc., the State's external quality review organization.
Hybrid Measures	Measures that can be reported using the hybrid method.
IDSS	The Interactive Data Submission System, a tool used to submit data to NCQA.
IPV	Inactivated polio virus vaccine.
IS	Information system: an automated system for collecting, processing, and transmitting data.
IS Standards	Information System (IS) standards: an NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data.[12-1]

[12-1] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

Term	Description
LPL	Low performance level. (For most performance measures, MDHHS defined the LPL as the most recent national Medicaid 25th percentile. For measures such as *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]*, in which lower rates in indicate better performance, the 75th percentile [rather than the 25th percentile] is considered the LPL).
Material Bias	For most measures reported as a rate, any error that causes a ± 5 percent difference in the reported rate is considered materially biased. For non-rate measures, any error that causes a ± 10 percent difference in the reported rate or calculation is considered materially biased.
Medical Record Validation	The process that the MHP's medical record abstraction staff uses to identify numerator positive cases.
Medicaid Percentiles	The NCQA national percentiles for each HEDIS measure for the Medicaid product line used to compare the MHP's performance and assess the reliability of the MHP's HEDIS rates.
MA	Medicaid Average.
MDHHS	Michigan Department of Health and Human Services.
MHP	Medicaid health plan.
MMR	Measles, mumps, and rubella vaccine.
MRR	Medical record review.
MWA	Medicaid Weighted Average.
MY	Measurement year.
NA	Small Denominator: indicates that the MHP followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in an NA designation.
NB	No Benefit: indicates that the required benefit to calculate the measure was not offered.
NCQA	The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed healthcare delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the healthcare provided within the managed care industry.
NR	Not Reported: indicates that the MHP chose not to report the required HEDIS 2019 measure indicator rate. This designation was assigned to rates during previous reporting years to indicate one of the following designations: The MHP chose not to report the required measure indicator rate, or the MHP's reported rate was invalid.
Numerator	The number of members in the denominator who received all the services as specified in the measure.
NQ	Not Required: indicates that the MHP was not required to report this measure.

Term	Description
OB/GYN	Obstetrician/Gynecologist.
O/E	Observed/Expected.
PCP	Primary care practitioner.
PCV	Pneumococcal conjugate vaccine.
POP	Eligible population.
Provider Data	Electronic files containing information about physicians such as type of physician, specialty, reimbursement arrangement, and office location.
RV	Rotavirus vaccine.
Software Vendor	A third party, with source code certified by NCQA, that contracts with the MHP to write source code for HEDIS measures. (For the measures to be certified, the vendor must submit programming codes associated with the measure to NCQA for automated testing of program logic, and a minimum percentage of the measures must receive a "Pass" or "Pass With Qualifications" designation.)
Tdap	Tetanus, diphtheria toxoids, and acellular pertussis vaccine.
uACR	Urine albumin-creatinine ratio.
UN	Unaudited: indicates that the organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures.
URI	Upper respiratory infection.
Quality Compass	NCQA Quality Compass benchmark.
VZV	Varicella zoster virus (chicken pox) vaccine.

Appendix A. Tabular Results

Appendix A presents tabular results for each measure indicator. Where applicable, the results provided include the eligible population and rate as well as the Michigan MWA for HEDIS MY 2020, HEDIS MY 2021, and HEDIS MY 2022. Yellow shading with one cross (+) indicates that the HEDIS MY 2022 rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Child & Adolescent Care Performance Measure Results

Table A-1—MHP and MWA Results for Childhood Immunization Status

Plan	Eligible Population	Combination 3 Rate	Combination 7 Rate	Combination 10 Rate
AET	1,135	45.01%	37.47%	16.55%
BCC	6,693	57.91%	48.66%	26.28%
HAP	595	46.22%	39.33%	19.83%
MCL	5,372	54.99%	47.20%	23.36%
MER	12,276	58.88%	52.31%	25.30%
MOL	8,268	57.18%	48.91%	23.84%
PRI	5,256	63.50%+	55.72%+	32.85%
UNI	5,700	54.42%	45.21%	22.19%
UPP	1,090	65.69%+	53.28%	31.39%
HEDIS MY 2022 MWA		**57.62%**	**49.59%**	**25.29%**
HEDIS MY 2021 MWA		**55.46%**	**46.83%**	**27.22%**
HEDIS MY 2020 MWA		**64.00%**	**55.64%**	**33.22%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-2—MHP and MWA Results for Well-Child Visits in the First 30 Months of Life

Plan	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Eligible Population	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Rate	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Eligible Population	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Rate
AET	754	46.55%	1,153	52.30%
BCC	5,102	67.72%+	6,386	63.64%
HAP	389	52.44%	509	47.35%
MCL	3,942	65.02%+	5,478	62.08%
MER	9,442	55.37%	13,021	59.29%
MOL	6,346	60.34%+	8,298	62.30%
PRI	3,863	53.15%	5,157	59.86%
UNI	4,049	63.74%+	5,861	60.54%
UPP	860	70.23%+	1,053	68.09%+
HEDIS MY 2022 MWA		**60.06%+**		**60.86%**
HEDIS MY 2021 MWA		**58.84%**		**60.99%**
HEDIS MY 2020 MWA		**61.88%**		**67.71%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-3—MHP and MWA Results for Lead Screening in Children

Plan	Eligible Population	Rate
AET	1,135	42.58%
BCC	6,693	53.28%
HAP	597	48.74%
MCL	5,400	43.33%
MER	12,330	55.72%
MOL	8,316	57.66%
PRI	5,281	60.83%
UNI	5,729	59.12%
UPP	1,094	52.07%
HEDIS MY 2022 MWA		**54.78%**
HEDIS MY 2021 MWA		**54.69%**
HEDIS MY 2020 MWA		**73.44%**

Table A-4—MHP and MWA Results for Child and Adolescents Well-Care Visits

Plan	Ages 3 to 11 Years—Eligible Population	Ages 3 to 11 Years—Rate	Ages 12 to 17 Years—Eligible Population	Ages 12 to 17 Years—Rate	Ages 18 to 21 Years—Eligible Population	Ages 18 to 21 Years—Rate	Total—Eligible Population	Total—Rate
AET	8,453	52.67%	5,128	43.72%	3,532	24.46%	17,113	44.17%
BCC	50,018	59.79%+	27,918	48.29%	17,440	29.30%+	95,376	50.85%+
HAP	3,375	47.26%	1,604	36.91%	1,460	22.12%	6,439	38.98%
MCL	45,443	58.39%+	26,767	47.20%	16,601	23.31%	88,811	48.46%
MER	116,989	59.96%+	68,584	51.05%+	37,095	27.32%+	222,668	51.78%+
MOL	75,191	59.81%+	50,215	52.58%+	28,831	30.90%+	154,237	52.05%+
PRI	46,604	61.72%+	28,101	51.71%+	16,060	29.23%+	90,765	52.87%+
UNI	56,572	57.05%+	38,726	50.53%	21,522	30.71%+	116,820	50.04%+
UPP	9,743	56.40%+	5,900	50.27%	3,414	23.73%	19,057	48.65%
HEDIS MY 2022 MWA		**59.20%+**		**50.38%**		**28.31%+**		**50.89%+**
HEDIS MY 2021 MWA		**58.13%**		**49.93%**		**29.01%**		**50.49%**
HEDIS MY 2020 MWA		**50.92%**		**42.35%**		**27.36%**		**44.59%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-5—MHP and MWA Results for Immunizations for Adolescents

Plan	Eligible Population	Combination 1 (Meningococcal, Tdap) Rate	Combination 2 (Meningococcal, Tdap, HPV) Rate
AET	816	70.80%	24.57%
BCC	4,534	74.42%	28.89%
HAP	256	65.23%	17.19%
MCL	4,464	75.91%	28.47%
MER	11,880	78.59%+	27.49%
MOL	8,349	77.09%	29.88%
PRI	4,675	77.99%	33.60%
UNI	6,572	76.89%	31.14%
UPP	1,058	76.40%	28.47%
HEDIS MY 2022 MWA		**76.96%**	**29.35%**
HEDIS MY 2021 MWA		**76.64%**	**32.85%**
HEDIS MY 2020 MWA		**82.68%**	**37.95%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-6—MHP and MWA Results for Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase

Plan	Initiation Phase—Eligible Population	Initiation Phase—Rate	Continuation and Maintenance Phase—Eligible Population	Continuation and Maintenance Phase—Rate
AET	35	42.86%+	6	NA
BCC	924	46.65%+	236	61.86%+
HAP	32	28.13%	2	NA
MCL	1,220	46.97%+	448	58.26%+
MER	969	39.94%+	396	40.66%
MOL	1,590	43.84%+	462	56.28%+
PRI	1,828	34.74%	866	35.45%
UNI	1,298	44.45%+	333	51.35%
UPP	314	51.91%+	130	54.62%+
HEDIS MY 2022 MWA		**42.47%+**		**47.93%**
HEDIS MY 2021 MWA		**40.29%**		**51.24%**
HEDIS MY 2020 MWA		**46.03%**		**57.74%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Women—Adult Care Performance Measure Results

Table A-7—MHP and MWA Results for Chlamydia Screening in Women

Plan	Ages 16 to 20 Years—Eligible Population	Ages 16 to 20 Years—Rate	Ages 21 to 24 Years—Eligible Population	Ages 21 to 24 Years—Rate	Total—Eligible Population	Total—Rate
AET	1,082	65.99%+	1,314	67.43%+	2,396	66.78%+
BCC	5,198	60.81%+	6,400	65.78%+	11,598	63.55%+
HAP	302	64.90%+	677	66.17%+	979	65.78%+
MCL	5,503	52.46%+	5,594	62.53%+	11,097	57.54%+
MER	12,445	61.07%+	10,943	70.85%+	23,388	65.64%+
MOL	9,343	62.27%+	8,153	67.89%+	17,496	64.89%+
PRI	5,361	57.75%+	4,877	65.55%+	10,238	61.47%+
UNI	6,662	59.47%+	5,734	63.50%+	12,396	61.33%+
UPP	1,192	43.20%	1,029	48.69%	2,221	45.75%
HEDIS MY 2022 MWA		**59.35%+**		**66.34%+**		**62.76%+**
HEDIS MY 2021 MWA		**58.09%**		**64.15%**		**61.00%**
HEDIS MY 2020 MWA		**57.30%**		**63.68%**		**60.20%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-8—MHP and MWA Results for Cervical Cancer Screening in Women

Plan	Cervical Cancer Screening—Eligible Population	Cervical Cancer Screening—Rate
AET	13,452	47.69%
BCC	79,390	60.30%+
HAP	8,283	56.45%
MCL	59,322	55.06%
MER	143,287	60.34%+
MOL	89,490	59.37%+
PRI	57,301	61.31%+
UNI	66,985	58.88%+
UPP	14,392	61.80%+
HEDIS MY 2022 MWA		**59.16%+**
HEDIS MY 2021 MWA		**58.01%**
HEDIS MY 2020 MWA		**60.53%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-9—MHP and MWA Results for Breast Cancer Screening in Women

Plan	Breast Cancer Screening—Eligible Population	Breast Cancer Screening—Rate
AET	3,115	47.70%
BCC	12,862	53.29%+
HAP	1,645	54.95%+
MCL	10,958	54.65%+
MER	28,208	53.52%+
MOL	18,773	53.48%+
PRI	10,369	53.81%+
UNI	12,809	53.45%+
UPP	3,426	59.84%+
HEDIS MY 2022 MWA		**53.68%+**
HEDIS MY 2021 MWA		**52.30%**
HEDIS MY 2020 MWA		**56.31%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Access to Care Performance Measure Results

Table A-10—MHP and MWA Results for Adults' Access to Preventive/Ambulatory Health Services

Plan	Ages 20 to 44 Years—Eligible Population	Ages 20 to 44 Years—Rate	Ages 45 to 64 Years—Eligible Population	Ages 45 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	21,071	64.22%	10,075	77.24%	3,166	89.13%+	34,312	70.34%
BCC	110,219	74.19%+	55,572	81.71%	1,004	76.10%	166,795	76.71%+
HAP	13,715	61.17%	6,740	74.93%	2,551	90.91%+	23,006	68.50%
MCL	90,904	70.38%	43,198	80.64%	371	72.24%	134,473	73.68%
MER	188,811	74.69%+	89,004	83.70%+	9,804	88.39%+	287,619	77.94%+
MOL	120,401	74.44%+	59,904	84.26%+	6,779	91.93%+	187,084	78.22%+
PRI	78,295	70.74%	36,617	81.44%	3,283	89.64%+	118,195	74.58%
UNI	92,874	73.00%	46,538	84.17%+	3,053	90.27%+	142,465	77.02%+
UPP	18,671	75.03%+	10,539	83.39%+	1,934	94.52%+	31,144	79.06%+
HEDIS MY 2022 MWA		**72.86%**		**82.59%+**		**89.52%+**		**76.43%**
HEDIS MY 2021 MWA		**75.38%**		**84.06%**		**89.55%**		**78.58%**
HEDIS MY 2020 MWA		**74.60%**		**84.05%**		**88.77%**		**78.22%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-11—MHP and MWA Results for Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

Plan	Ages 3 Months to 17 Years—Eligible Population	Ages 3 Months to 17 Years—Rate	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	427	75.41%+	433	43.19%	40	12.50%	900	57.11%+
BCC	2,617	64.35%	2,522	37.99%	11	NA	5,150	51.38%
HAP	195	62.05%	211	38.86%	30	23.33%	436	48.17%
MCL	2,182	72.09%+	2,031	43.48%	3	NA	4,216	58.28%+
MER	5,813	68.23%+	4,881	40.18%	93	40.86%	10,787	55.30%+
MOL	4,628	60.54%	3,201	37.83%	81	27.16%	7,910	51.01%
PRI	1,494	77.98%+	1,387	53.86%+	26	NA	2,907	66.36%+
UNI	3,042	60.75%	2,418	36.89%	33	27.27%	5,493	50.05%
UPP	370	78.11%+	325	45.85%+	15	NA	710	62.25%+
HEDIS MY 2022 MWA		**66.30%**		**40.61%**		**32.23%**		**54.40%**
HEDIS MY 2021 MWA		**64.93%**		**45.77%**		**40.94%**		**51.78%**
HEDIS MY 2020 MWA		**61.42%**		**39.69%**		**32.87%**		**50.15%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-12—MHP and MWA Results for Appropriate Testing for Pharyngitis[1]

Plan	Ages 3 to 17 Years—Eligible Population	Ages 3 to 17 Years—Rate	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population	Ages 65+ Years—Rate	Total—Eligible Population	Total—Rate
AET	476	61.97%	679	51.99%	12	NA	1,167	55.61%
BCC	3,783	66.77%	4,941	52.36%	7	NA	8,731	58.60%
HAP	199	63.32%	378	55.82%	17	NA	594	57.41%
MCL	5,019	79.96%+	4,179	66.43%+	2	NA	9,200	73.79%+
MER	11,599	72.53%	8,514	56.44%	66	21.21%+	20,179	65.57%
MOL	8,570	64.87%	6,051	50.69%	64	25.00%+	14,685	58.85%
PRI	1,803	75.37%	1,896	62.66%+	5	NA	3,704	68.84%
UNI	6,057	62.95%	5,132	42.32%	52	17.31%+	11,241	53.32%
UPP	571	85.29%+	554	78.52%+	6	NA	1,131	81.70%+
HEDIS MY 2022 MWA		**69.83%**		**54.43%**		**22.51%+**		**62.63%**
HEDIS MY 2021 MWA		**69.04%**		**53.55%**		**14.78%**		**60.58%**
HEDIS MY 2020 MWA		**75.34%**		**57.61%**		**25.00%**		**68.56%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.

Table A-13—MHP and MWA Results for Appropriate Treatment for Upper Respiratory Infection

Plan	Ages 3 Months to 17 Years—Eligible Population	Ages 3 Months to 17 Years—Rate	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 Years and Older—Eligible Population	Ages 65 Years and Older—Rate	Total—Eligible Population	Total—Rate
AET	3,106	92.53%	1,556	81.81%+	79	64.56%	4,741	88.55%
BCC	21,885	92.77%	12,118	79.72%	27	NA	34,030	88.11%
HAP	1,398	92.49%	939	81.79%+	74	68.92%	2,411	87.60%
MCL	16,004	91.63%	8,887	83.56%+	10	NA	24,901	88.75%
MER	46,133	92.54%	20,168	81.88%+	215	66.98%	66,516	89.23%
MOL	35,541	91.45%	13,269	79.77%	194	65.98%	49,004	88.19%
PRI	16,531	95.72%+	7,393	90.21%+	72	90.28%+	23,996	94.01%+
UNI	26,733	91.92%	10,605	76.01%	106	71.70%	37,444	87.36%
UPP	3,163	93.17%	1,614	85.01%+	38	68.42%	4,815	90.24%
HEDIS MY 2022 MWA		**92.48%**		**81.42%+**		**70.18%**		**88.99%**
HEDIS MY 2021 MWA		**94.11%**		**82.21%**		**75.51%**		**89.59%**
HEDIS MY 2020 MWA		**91.30%**		**78.18%**		**71.33%**		**87.28%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Obesity Performance Measure Results

Table A-14—MHP and MWA Results for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Plan	Eligible Population	BMI Percentile—Total—Rate	Counseling for Nutrition—Total—Rate	Counseling for Physical Activity—Total—Rate
AET	8,775	82.00%+	73.97%+	70.56%+
BCC	56,449	81.51%+	75.00%+	72.92%+
HAP	2,614	85.67%+	78.96%+	76.52%+
MCL	53,309	66.83%	57.32%	56.59%
MER	137,370	81.02%+	69.34%	68.86%+
MOL	95,168	78.10%	69.59%	68.37%
PRI	54,657	88.56%+	80.29%+	79.32%+
UNI	66,601	83.94%+	73.97%+	70.56%+
UPP	12,169	92.94%+	75.43%+	70.32%+
HEDIS MY 2022 MWA		**80.54%+**	**70.88%**	**69.40%+**
HEDIS MY 2021 MWA		**76.87%**	**70.12%**	**68.90%**
HEDIS MY 2020 MWA		**78.53%**	**69.51%**	**67.60%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Pregnancy Care Performance Measure Results

Table A-15—MHP and MWA Results for Prenatal and Postpartum Care

Plan	Eligible Population	Timeliness of Prenatal Care—Rate[1]	Postpartum Care—Rate
AET	840	64.48%	61.80%
BCC	4,958	86.86%+	76.40%
HAP	515	79.21%	68.68%
MCL	4,029	71.86%	75.96%
MER	8,964	74.45%	75.91%
MOL	6,450	81.02%	71.53%
PRI	3,896	80.78%	80.05%+
UNI	4,434	77.37%	74.70%
UPP	765	92.94%+	89.29%+
HEDIS MY 2022 MWA		**78.45%**	**75.33%**
HEDIS MY 2021 MWA		**79.45%**	**73.36%**
HEDIS MY 2020 MWA		**79.54%**	**70.13%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.

Living With Illness Performance Measure Results

Table A-16—MHP and MWA Results for HbA1c Control for Patients With Diabetes

Plan	Eligible Population	HbA1c Control (<8.0%)—Rate	Poor HbA1c Control (>9.0%)—Rate*
AET	3,753	52.55%+	37.96%+
BCC	15,471	59.61%+	34.06%+
HAP	2,453	56.20%+	35.77%+
MCL	12,256	34.79%	58.64%
MER	28,375	54.99%+	38.93%+
MOL	20,905	50.61%+	41.85%
PRI	10,769	57.66%+	30.41%+
UNI	15,406	59.12%+	33.09%+
UPP	2,874	61.07%+	30.17%+
HEDIS MY 2022 MWA		**53.53%+**	**39.01%+**
HEDIS MY 2021 MWA		**48.26%**	**43.04%**
HEDIS MY 2020 MWA		**47.46%**	**43.03%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.
** For this indicator, a lower rate indicates better performance.*

Table A-17—MHP and MWA Results for Eye Exam for Patients With Diabetes

Plan	Eligible Population	Eye Exam (Retinal) Performed—Rate
AET	3,753	54.26%+
BCC	15,471	54.01%+
HAP	2,453	58.88%+
MCL	12,256	52.55%+
MER	28,375	55.23%+
MOL	20,909	53.53%+
PRI	10,804	54.48%+
UNI	15,406	56.93%+
UPP	2,874	60.83%+
HEDIS MY 2022 MWA		**54.81%+**
HEDIS MY 2021 MWA		**54.56%**
HEDIS MY 2020 MWA		**53.65%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-18—MHP and MWA Results for Blood Pressure Control for Patient With Diabetes

Plan	Eligible Population	Blood Pressure Control (<140 90 mm Hg)—Rate
AET	3,753	59.12%
BCC	15,471	70.07%+
HAP	2,453	61.07%+
MCL	12,256	47.69%
MER	28,375	67.88%+
MOL	20,908	67.64%+
PRI	10,769	68.61%+
UNI	15,406	75.18%+
UPP	2,874	82.00%+
HEDIS MY 2022 MWA		**66.93%+**
HEDIS MY 2021 MWA		**59.61%**
HEDIS MY 2020 MWA		**58.38%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-19—MHP and MWA Results for Kidney Health Evaluation for People With Diabetes

Plan	Ages 18 to 64 Years—Eligible Population	Ages 18 to 64 Years—Rate	Ages 65 to 74 Years—Eligible Population	Ages 65 to 74 Years—Rate	Ages 75 to 85 Years—Eligible Population	Ages 75 to 85 Years—Rate	Total—Eligible Population	Total—Rate
AET	2,888	23.13%	565	28.85%	188	25.00%	3,641	24.11%
BCC	15,002	34.76%+	203	40.39%+	58	37.93%+	15,263	34.85%+
HAP	1,854	37.86%+	454	44.93%+	174	43.10%+	2,482	39.52%+
MCL	12,029	30.99%	63	20.63%	20	NA	12,112	30.94%
MER	26,095	39.26%+	1,952	34.38%	413	29.30%	28,460	38.78%+
MOL	18,764	28.90%	1,480	31.82%	361	26.87%	20,605	29.07%
PRI	9,958	35.93%+	588	39.29%+	157	41.40%+	10,703	36.20%+
UNI	14,452	40.62%+	698	51.15%+	181	57.46%+	15,331	41.30%+
UPP	2,529	36.10%+	270	36.67%+	71	29.58%	2,870	35.99%+
HEDIS MY 2022 MWA		**35.09%+**		**36.52%+**		**34.44%**		**35.16%+**
HEDIS MY 2021 MWA		**30.62%**		**29.92%**		**30.27%**		**30.57%**
HEDIS MY 2020 MWA		**30.63%**		**32.03%**		**29.97%**		**30.68%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-20—MHP and MWA Results for Asthma Medication Ratio

Plan	Eligible Population	Total—Rate
AET	705	52.77%
BCC	4,602	49.04%
HAP	246	52.03%
MCL	4,758	54.48%
MER	7,950	61.16%
MOL	5,458	55.51%
PRI	3,172	65.61%+
UNI	4,007	62.79%
UPP	1,075	57.67%
HEDIS MY 2022 MWA		**57.73%**
HEDIS MY 2021 MWA		**56.36%**
HEDIS MY 2020 MWA		**56.83%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-21—MHP and MWA Results for Controlling High Blood Pressure

Plan	Eligible Population	Controlling High Blood Pressure—Rate
AET	6,146	57.91%
BCC	24,936	58.81%
HAP	3,978	62.53%+
MCL	18,980	46.47%
MER	45,582	62.77%+
MOL	33,156	63.26%+
PRI	15,730	73.24%+
UNI	23,283	65.45%+
UPP	4,472	79.08%+
HEDIS MY 2022 MWA		**62.07%+**
HEDIS MY 2021 MWA		**56.14%**
HEDIS MY 2020 MWA		**54.48%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-22—MHP and MWA Results for Antidepressant Medication Management

Plan	Eligible Population	Effective Acute Phase Treatment—Rate	Effective Continuation Phase Treatment—Rate
AET	249	69.48%+	53.01%+
BCC	6,134	66.06%+	48.81%+
HAP	495	78.79%+	67.27%+
MCL	6,218	69.22%+	54.25%+
MER	7,250	72.10%+	69.38%+
MOL	6,207	66.20%+	48.69%+
PRI	8,476	78.81%+	66.20%+
UNI	5,053	61.19%+	43.28%+
UPP	1,345	73.09%+	55.69%+
HEDIS MY 2022 MWA		**70.03%+**	**56.56%+**
HEDIS MY 2021 MWA		**65.68%**	**49.31%**
HEDIS MY 2020 MWA		**59.28%**	**42.98%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-23—MHP and MWA Results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Plan	Eligible Population	Rate
AET	773	78.40%
BCC	3,097	79.85%+
HAP	482	82.16%+
MCL	5,083	79.13%
MER	6,786	83.41%+
MOL	4,579	81.31%+
PRI	3,042	78.57%
UNI	2,804	85.09%+
UPP	911	86.61%+
HEDIS MY 2022 MWA		**81.45%+**
HEDIS MY 2021 MWA		**80.95%**
HEDIS MY 2020 MWA		**78.01%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-24—MHP and MWA Results for Diabetes Monitoring for People With Diabetes and Schizophrenia

Plan	Eligible Population	Rate
AET	131	54.96%
BCC	211	63.51%
HAP	81	64.20%
MCL	318	64.78%
MER	563	75.84%+
MOL	673	64.49%
PRI	251	64.94%
UNI	334	65.57%
UPP	83	73.49%+
HEDIS MY 2022 MWA		**66.84%**
HEDIS MY 2021 MWA		**65.67%**
HEDIS MY 2020 MWA		**61.98%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Table A-25—MHP and MWA Results for Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

Plan	Eligible Population	Rate
AET	21	NA
BCC	29	NA
HAP	5	NA
MCL	46	69.57%
MER	73	75.34%
MOL	94	71.28%
PRI	28	NA
UNI	47	65.96%
UPP	14	NA
HEDIS MY 2022 MWA		**70.31%**
HEDIS MY 2021 MWA		**66.39%**
HEDIS MY 2020 MWA		**64.95%**

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table A-26—MHP and MWA Results for Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Plan	Eligible Population	Rate
AET	556	62.95%+
BCC	1,022	57.63%
HAP	323	61.30%
MCL	1,810	64.81%+
MER	2,188	64.90%+
MOL	2,413	66.14%+
PRI	1,235	64.13%+
UNI	1,256	60.59%
UPP	387	82.69%+
HEDIS MY 2022 MWA		**64.33%+**
HEDIS MY 2021 MWA		**65.80%**
HEDIS MY 2020 MWA		**68.17%**

Yellow shading with one cross (+) indicates the HEDIS MY 2022 MHP or MWA rate was at or above the Quality Compass HEDIS MY 2021 MWA national Medicaid 50th percentile.

Health Plan Diversity and Utilization Measure Results

The Health Plan Diversity and Utilization measures' MHP and MWA results are presented in tabular format in Section 9 and Section 10 of this report, respectively.

Appendix B. Trend Tables

Appendix B includes trend tables for the MHPs. Where applicable, each measure's HEDIS MY 2020, HEDIS MY 2021, and HEDIS MY 2022 rates are presented as well as the HEDIS MY 2021 to HEDIS MY 2022 rate comparison and the HEDIS MY 2022 Performance Level. HEDIS MY 2021 and HEDIS MY 2022 rates were compared based on a Chi-square test of statistical significance with a *p* value <0.05. Values in the MY 2021–MY 2022 Comparison column that are shaded green with one cross ($^{+}$) indicate significant improvement from the previous year. Values in the MY 2021–MY 2022 Comparison column shaded red with two crosses ($^{++}$) indicate a significant decline in performance from the previous year.

Details regarding the trend analysis and performance ratings are found in Section 2.

Table B-1—AET Trend Table

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	49.38%	45.74%	45.01%	-0.73	★
Combination 7	40.63%	35.28%	37.47%	+2.19	★
Combination 10	18.13%	18.00%	16.55%	-1.45	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	41.30%	46.55%	+5.25^{+}	★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	41.89%	52.30%	+10.41^{+}	★
Lead Screening in Children					
Lead Screening in Children	62.83%	52.31%	42.58%	**-9.73^{++}**	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	52.37%	52.67%	+0.30	★★
Ages 12 to 17 Years	—	44.76%	43.72%	-1.04	★
Ages 18 to 21 Years	—	24.29%	24.46%	+0.17	★★
Total	—	44.00%	44.17%	+0.17	★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	79.56%	69.10%	70.80%	+1.70	★
Combination 2 (Meningococcal, Tdap, HPV)	37.23%	29.20%	24.57%	-4.63	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	36.53%	38.24%	42.86%	+4.62	★★★
Continuation and Maintenance Phase	45.95%	NA	NA	NC	NC
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	57.01%	65.21%	65.99%	+0.78	★★★★
Ages 21 to 24 Years	63.88%	65.67%	67.43%	+1.76	★★★★
Total	60.30%	65.46%	66.78%	+1.32	★★★★
Cervical Cancer Screening					
Cervical Cancer Screening	54.01%	46.47%	47.69%	+1.22	★
Breast Cancer Screening					
Breast Cancer Screening	50.35%	46.79%	47.70%	+0.91	★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	65.40%	66.48%	64.22%	**-2.26^{++}**	★
Ages 45 to 64 Years	79.70%	78.54%	77.24%	**-1.30^{++}**	★★
Ages 65 Years and Older	87.72%	89.64%	89.13%	-0.51	★★★
Total	72.90%	72.49%	70.34%	**-2.15^{++}**	★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	61.25%	68.24%	75.41%	+7.17	★★★★
Ages 18 to 64 Years	43.03%	52.86%	43.19%	**-9.67^{++}**	★★
Ages 65 Years And Older	28.36%	NA	12.50%	NC	★
Total	48.75%	54.87%	57.11%	+2.24	★★★
Appropriate Testing for Pharyngitis [4]					
Ages 3 to 17 Years	68.58%	63.11%	61.97%	-1.14	★
Ages 18 to 64 Years	49.81%	50.94%	51.99%	+1.05	★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	59.23%	53.84%	55.61%	+1.77	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	91.28%	94.63%	92.53%	**-2.10^{++}**	★★
Ages 18 to 64 Years	80.28%	84.80%	81.81%	-2.99	★★★
Ages 65 Years And Older	70.00%	73.81%	64.56%	-9.25	★
Total	87.04%	90.39%	88.55%	**-1.84^{++}**	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	80.29%	82.97%	82.00%	-0.97	★★★
Counseling for Nutrition—Total	72.02%	73.48%	73.97%	+0.49	★★★
Counseling for Physical Activity—Total	68.61%	71.78%	70.56%	-1.22	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care [4]	68.86%	70.07%	64.48%	-5.59	★
Postpartum Care	54.01%	58.64%	61.80%	+3.16	★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)**	48.91%	41.36%	37.96%	-3.40	★★★
HbA1c Control (<8.0%)	44.04%	50.12%	52.55%	+2.43	★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	45.74%	51.58%	54.26%	+2.68	★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	52.07%	51.34%	59.12%	+7.78+	★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	20.01%	23.13%	+3.12+	★
Ages 65 to 74 Years	—	23.71%	28.85%	+5.14+	★★
Ages 75 to 85 Years	—	23.35%	25.00%	+1.65	★
Total	—	20.82%	24.11%	+3.29+	★
Asthma Medication Ratio					
Total	50.39%	50.15%	52.77%	+2.62	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	60.10%	57.91%	-2.19	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	51.32%	67.11%	69.48%	+2.37	★★★★
Effective Continuation Phase Treatment	37.48%	51.11%	53.01%	+1.90	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	62.95%	77.48%	78.40%	+0.92	★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	52.49%	55.97%	54.96%	-1.01	★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	63.54%	61.32%	62.95%	+1.63	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
White	32.58%	34.86%	3.70%	-31.16	NC
Black or African American	53.80%	53.11%	3.42%	-49.69	NC
American Indian or Alaska Native	0.19%	0.39%	0.02%	-0.37	NC
Asian	1.16%	0.99%	0.08%	-0.91	NC
Native Hawaiian and Other Pacific Islander	0.08%	0.09%	0.01%	-0.08	NC
Some Other Race	0.00%	0.00%	0.08%	+0.08	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Unknown	6.03%	3.99%	92.11%	+88.12	NC
Declined	6.16%	6.57%	0.57%	-6.00	NC
Ethnicity Reporting Category: Hispanic or Latino	3.62%	0.83%	0.09%	-0.74	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	0.00%	0.00%	0.00%	0.00	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.00%	0.00	NC
Spoken Language Preferred for Health Care—Unknown	100.00%	100.00%	100.00%	0.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	NC

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Language Preferred for Written Materials—Unknown	100.00%	100.00%	100.00%	0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	97.73%	96.60%	96.25%	-0.35	NC
Other Language Needs—Non-English	0.99%	1.10%	1.28%	+0.18	NC
Other Language Needs—Unknown	1.28%	2.30%	2.47%	+0.17	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care					
*Emergency Department Visits**	671.64	709.69	712.18	+2.49	★
Outpatient Visits	6,611.4	4,188.23	4,199.45	+11.22	NC
Inpatient Utilization—General Hospital/Acute Care					
Discharges—Total Inpatient—Total All Ages	126.36	98.78	84.57	-14.21	NC
Average Length of Stay—Total Inpatient—Total All Ages	5.6	5.59	6.14	+0.55	NC
Discharges—Maternity—Total All Ages	27.84	24.13	21.08	-3.05	NC
Average Length of Stay—Maternity—Total All Ages	2.58	2.42	2.44	+0.02	NC
Discharges—Surgery—Total All Ages	30	25.88	23.33	-2.55	NC
Average Length of Stay—Surgery—Total All Ages	9.05	9.16	9.51	+0.35	NC
Discharges—Medicine—Total All Ages	76.08	54.83	45.48	-9.35	NC
Average Length of Stay—Medicine—Total All Ages	5.05	4.94	5.70	+0.76	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	14.94%	15.63%	16.38%	+0.75	★★★
Multiple Pharmacies	3.43%	2.31%	3.26%	**+0.95++**	★★
Multiple Prescribers and Multiple Pharmacies	2.23%	1.78%	2.43%	+0.65	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.53%	2.65%	2.81%	+0.16	★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	16.92%	9.59%	9.81%	+0.22	★
At Least 31 Days Covered—Total	9.03%	7.13%	7.14%	+0.01	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	11.42%	11.99%	13.85%	+1.86	★
*Expected Readmissions—Total**	9.91%	10.74%	10.73%	-0.01	★
*O/E Ratio—Total**	1.15	1.1158	1.2912	**+0.17++**	★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2022 Performance Levels were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2021 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2022 or MY 2021–MY 2022 Comparisons provided for these measures are for information only.

4 Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2022 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Table B-2—BCC Trend Table

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	62.53%	55.96%	57.91%	+1.95	★
Combination 7	52.55%	48.18%	48.66%	+0.48	★
Combination 10	31.39%	30.66%	26.28%	-4.38	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	61.80%	67.72%	+5.92+	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	62.98%	63.64%	+0.66	★★
Lead Screening in Children					
Lead Screening in Children	71.53%	55.23%	53.28%	-1.95	★★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	59.20%	59.79%	+0.59	★★★
Ages 12 to 17 Years	—	49.83%	48.29%	**-1.54++**	★★
Ages 18 to 21 Years	—	31.08%	29.30%	**-1.78++**	★★★
Total	—	51.22%	50.85%	-0.37	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	82.00%	74.45%	74.42%	-0.03	★★
Combination 2 (Meningococcal, Tdap, HPV)	34.06%	32.12%	28.89%	-3.23	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	48.33%	43.94%	46.65%	+2.71	★★★★
Continuation and Maintenance Phase	68.62%	62.04%	61.86%	-0.18	★★★★
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	58.99%	58.41%	60.81%	+2.40+	★★★★
Ages 21 to 24 Years	64.86%	63.32%	65.78%	+2.46+	★★★
Total	61.98%	61.08%	63.55%	+2.47+	★★★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cervical Cancer Screening					
Cervical Cancer Screening	60.73%	59.49%	60.30%	+0.81	★★★
Breast Cancer Screening					
Breast Cancer Screening	55.48%	52.25%	53.29%	+1.04	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	74.84%	76.86%	74.19%	**-2.67++**	★★★
Ages 45 to 64 Years	82.29%	83.45%	81.71%	**-1.74++**	★★
Ages 65 Years and Older	71.52%	76.97%	76.10%	-0.87	★
Total	77.48%	79.06%	76.71%	**-2.35++**	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	62.81%	65.57%	64.35%	-1.22	★★
Ages 18 to 64 Years	38.45%	43.80%	37.99%	**-5.81++**	★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	49.46%	49.46%	51.38%	+1.92	★★
Appropriate Testing for Pharyngitis [4]					
Ages 3 to 17 Years	75.69%	70.29%	66.77%	**-3.52++**	★
Ages 18 to 64 Years	54.39%	50.67%	52.36%	+1.69	★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	65.57%	57.21%	58.60%	+1.39	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	91.91%	94.71%	92.77%	**-1.94++**	★★
Ages 18 to 64 Years	76.51%	81.42%	79.72%	**-1.70++**	★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	86.34%	88.76%	88.11%	**-0.65++**	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	78.14%	83.07%	81.51%	-1.56	★★★
Counseling for Nutrition—Total	64.87%	76.56%	75.00%	-1.56	★★★
Counseling for Physical Activity—Total	63.80%	75.26%	72.92%	-2.34	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care [4]	78.91%	88.08%	86.86%	-1.22	★★★
Postpartum Care	71.09%	78.59%	76.40%	-2.19	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)**	41.61%	37.96%	34.06%	-3.90	★★★★
HbA1c Control (<8.0%)	49.15%	50.85%	59.61%	+8.76+	★★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	58.64%	54.99%	54.01%	-0.98	★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	56.93%	59.37%	70.07%	+10.70+	★★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	28.07%	34.76%	+6.69+	★★★
Ages 65 to 74 Years	—	29.59%	40.39%	+10.80+	★★★
Ages 75 to 85 Years	—	25.53%	37.93%	+12.40	★★★
Total	—	28.08%	34.85%	+6.77+	★★★
Asthma Medication Ratio					
Total	50.13%	49.01%	49.04%	+0.03	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	57.95%	58.81%	+0.86	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	62.35%	68.44%	66.06%	-2.38++	★★★★
Effective Continuation Phase Treatment	47.14%	52.44%	48.81%	-3.63++	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.17%	81.37%	79.85%	-1.52	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	66.67%	59.60%	63.51%	+3.91	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.66%	57.08%	57.63%	+0.55	★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
White	46.98%	50.27%	51.82%	+1.55	NC
Black or African American	34.60%	34.93%	35.10%	+0.17	NC
American Indian or Alaska Native	1.01%	1.39%	1.28%	-0.11	NC
Asian	1.77%	1.72%	1.97%	+0.25	NC
Native Hawaiian and Other Pacific Islander	3.26%	2.94%	2.58%	-0.36	NC
Some Other Race	0.00%	0.00%	0.01%	+0.01	NC
Two or More Races	0.04%	0.03%	0.02%	-0.01	NC
Unknown	12.35%	8.73%	7.20%	-1.53	NC
Declined	0.00%	0.00%	0.01%	+0.01	NC
Ethnicity Reporting Category: Hispanic or Latino	3.11%	2.90%	6.07%	+3.17	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.39%	98.33%	96.48%	-1.85	NC
Spoken Language Preferred for Health Care—Non-English	1.61%	1.66%	3.43%	+1.77	NC
Spoken Language Preferred for Health Care—Unknown	0.01%	0.01%	0.09%	+0.08	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	98.38%	98.33%	96.65%	-1.68	NC
Language Preferred for Written Materials—Non-English	1.62%	1.67%	3.28%	+1.61	NC

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Language Preferred for Written Materials—Unknown	0.01%	0.01%	0.07%	+0.06	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	98.80%	98.72%	98.46%	-0.26	NC
Other Language Needs—Non-English	1.19%	1.27%	1.53%	+0.26	NC
Other Language Needs—Unknown	0.01%	0.01%	0.01%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care					
*ED Visits **	532.56	542.29	550.05	+7.76	★★
Outpatient Visits	4,014.84	4,494.71	4,441.93	-52.78	NC
Inpatient Utilization—General Hospital/Acute Care					
Discharges—Total Inpatient—Total All Ages	74.16	82.28	70.93	-11.35	NC
Average Length of Stay—Total Inpatient—Total All Ages	4.4	4.69	4.92	+0.23	NC
Discharges—Maternity—Total All Ages	30.36	27.22	23.94	-3.28	NC
Average Length of Stay—Maternity—Total All Ages	2.41	2.77	2.87	+0.10	NC
Discharges—Surgery—Total All Ages	14.4	18.15	17.35	-0.80	NC
Average Length of Stay—Surgery—Total All Ages	7.67	7.99	8.19	+0.20	NC
Discharges—Medicine—Total All Ages	36.36	42.85	34.83	-8.02	NC
Average Length of Stay—Medicine—Total All Ages	4.38	4.24	4.40	+0.16	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	14.62%	17.63%	17.25%	-0.38	★★★
Multiple Pharmacies	3.00%	2.96%	2.42%	-0.54^{+}	★★
Multiple Prescribers and Multiple Pharmacies	1.84%	2.09%	1.63%	-0.46^{+}	★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	1.69%	1.31%	0.80%	-0.51^{+}	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	8.40%	8.14%	7.56%	-0.58^{+}	★★
At Least 31 Days Covered—Total	5.69%	5.78%	5.37%	-0.41	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	11.00%	9.98%	10.65%	+0.67	★★
*Expected Readmissions—Total**	10.23%	9.88%	10.25%	+0.37	★
*O/E Ratio—Total**	1.08	1.0096	1.0390	**+0.03^{++}**	★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. 2021–2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]HEDIS MY 2022 Performance Levels were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2021 benchmark.
[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2022 or MY 2021–MY 2022 Comparisons provided for these measures are for information only.
[4] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2022 and prior years be considered with caution.
** For this indicator, a lower rate indicates better performance.*
— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
HEDIS MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table B-3—HAP Trend Table

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	44.95%	37.89%	46.22%	+8.33+	★
Combination 7	37.61%	29.64%	39.33%	+9.69+	★
Combination 10	20.18%	15.46%	19.83%	+4.37	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	36.06%	52.44%	+16.38+	★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	46.05%	47.35%	+1.30	★
Lead Screening in Children					
Lead Screening in Children	62.39%	44.59%	48.74%	+4.15	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	45.80%	47.26%	+1.46	★
Ages 12 to 17 Years	—	34.35%	36.91%	+2.56	★
Ages 18 to 21 Years	—	19.18%	22.12%	+2.94	★★
Total	—	36.69%	38.98%	+2.29+	★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	70.73%	60.55%	65.23%	+4.68	★
Combination 2 (Meningococcal, Tdap, HPV)	21.95%	18.81%	17.19%	-1.62	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	NA	34.38%	28.13%	-6.25	★
Continuation and Maintenance Phase	NA	NA	NA	NC	NC
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	51.98%	55.87%	64.90%	+9.03+	★★★★
Ages 21 to 24 Years	59.75%	60.48%	66.17%	+5.69+	★★★
Total	56.42%	58.96%	65.78%	+6.82+	★★★★
Cervical Cancer Screening					
Cervical Cancer Screening	40.00%	43.80%	56.45%	+12.65+	★★
Breast Cancer Screening					
Breast Cancer Screening	57.02%	56.75%	54.95%	-1.80	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	57.06%	60.43%	61.17%	+0.74	★
Ages 45 to 64 Years	74.49%	74.95%	74.93%	-0.02	★
Ages 65 Years and Older	88.16%	89.41%	90.91%	+1.50	★★★★
Total	68.81%	68.56%	68.50%	-0.06	★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	75.93%	71.05%	62.05%	-9.00	★★
Ages 18 to 64 Years	40.52%	44.90%	38.86%	-6.04	★★
Ages 65 Years And Older	29.55%	NA	23.33%	NC	★
Total	47.20%	50.98%	48.17%	-2.81	★
Appropriate Testing for Pharyngitis [4]					
Ages 3 to 17 Years	65.98%	65.56%	63.32%	-2.24	★
Ages 18 to 64 Years	47.10%	43.81%	55.82%	+12.01+	★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	52.76%	48.25%	57.41%	+9.16+	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	91.72%	95.76%	92.49%	-3.27++	★★
Ages 18 to 64 Years	79.94%	81.39%	81.79%	+0.40	★★★
Ages 65 Years And Older	73.75%	62.50%	68.92%	+6.42	★★
Total	84.31%	88.07%	87.60%	-0.47	★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	80.67%	81.42%	85.67%	+4.25	★★★★
Counseling for Nutrition—Total	69.85%	75.14%	78.96%	+3.82	★★★
Counseling for Physical Activity—Total	67.27%	73.50%	76.52%	+3.02	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care [4]	68.30%	75.88%	79.21%	+3.33	★
Postpartum Care	52.68%	64.57%	68.68%	+4.11	★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)**	46.96%	50.12%	35.77%	-14.35+	★★★
HbA1c Control (<8.0%)	46.47%	44.28%	56.20%	+11.92+	★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	44.77%	49.88%	58.88%	+9.00+	★★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	53.28%	53.28%	61.07%	+7.79+	★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	31.20%	37.86%	+6.66+	★★★
Ages 65 to 74 Years	—	33.55%	44.93%	+11.38+	★★★
Ages 75 to 85 Years	—	32.35%	43.10%	+10.75	★★★
Total	—	31.83%	39.52%	+7.69+	★★★
Asthma Medication Ratio					
Total	46.27%	48.30%	52.03%	+3.73	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	57.32%	62.53%	+5.21	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	70.59%	77.32%	78.79%	+1.47	★★★★★
Effective Continuation Phase Treatment	47.06%	63.41%	67.27%	+3.86	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	71.52%	76.61%	82.16%	+5.55+	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	66.67%	64.86%	64.20%	-0.66	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.04%	63.44%	61.30%	-2.14	★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
White	39.22%	41.61%	38.26%	-3.35	NC
Black or African American	46.62%	45.63%	42.88%	-2.75	NC
American Indian or Alaska Native	0.15%	0.50%	0.42%	-0.08	NC
Asian	1.74%	1.35%	1.30%	-0.05	NC
Native Hawaiian and Other Pacific Islander	0.04%	0.07%	0.11%	+0.04	NC
Some Other Race	3.98%	1.67%	1.11%	-0.56	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Unknown	8.24%	9.13%	15.90%	+6.77	NC
Declined	0.00%	0.04%	0.03%	-0.01	NC
Ethnicity Reporting Category: Hispanic or Latino	3.72%	0.91%	0.50%	-0.41	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	90.36%	99.10%	98.80%	-0.30	NC
Spoken Language Preferred for Health Care—Non-English	0.74%	0.00%	0.00%	0.00	NC
Spoken Language Preferred for Health Care—Unknown	8.91%	0.90%	1.20%	+0.30	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	90.36%	99.10%	98.80%	-0.30	NC
Language Preferred for Written Materials—Non-English	0.74%	0.00%	0.00%	0.00	NC

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Language Preferred for Written Materials—Unknown	8.91%	0.90%	1.20%	+0.30	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	90.36%	99.10%	98.80%	-0.30	NC
Other Language Needs—Non-English	0.74%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	8.91%	0.90%	1.20%	+0.30	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care					
*ED Visits—Total**	601.68	613.21	588.19	-25.02	★★
Outpatient Visits—Total	3,949.44	4,642.9	4,780.73	+137.83	NC
Inpatient Utilization—General Hospital/Acute Care					
Discharges—Total Inpatient—Total All Ages	122.4	108.36	104.55	-3.81	NC
Average Length of Stay—Total Inpatient—Total All Ages	5.95	6.08	5.77	-0.31	NC
Discharges—Maternity—Total All Ages	22.2	21.81	22.58	+0.77	NC
Average Length of Stay—Maternity—Total All Ages	2.57	2.45	2.48	+0.03	NC
Discharges—Surgery—Total All Ages	29.28	27.93	28.41	+0.48	NC
Average Length of Stay—Surgery—Total All Ages	9.44	9.55	9.55	0.00	NC
Discharges—Medicine—Total All Ages	77.04	63.69	58.52	-5.17	NC
Average Length of Stay—Medicine—Total All Ages	5.33	5.51	4.92	-0.59	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	12.95%	17.30%	16.79%	-0.51	★★★
Multiple Pharmacies	3.34%	2.92%	2.73%	-0.19	★★
Multiple Prescribers and Multiple Pharmacies	1.63%	2.37%	1.82%	-0.55	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.16%	1.94%	1.27%	-0.67	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	14.45%	11.94%	11.71%	-0.23	★
At Least 31 Days Covered—Total	9.91%	6.84%	5.53%	-1.31	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	13.38%	9.86%	8.83%	-1.03	★★★
*Expected Readmissions—Total**	9.81%	9.76%	10.44%	+0.68	★
*O/E Ratio—Total**	1.36	1.0099	0.8463	-0.16[+]	★★★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2021 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]HEDIS MY 2022 Performance Levels were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2021 benchmark.
[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2022 or MY 2021–MY 2022 Comparisons provided for these measures are for information only.
[4] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2022 and prior years be considered with caution.
** For this indicator, a lower rate indicates better performance.*
— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
HEDIS MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table B-4—MCL Trend Table

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	63.26%	58.88%	54.99%	-3.89	★
Combination 7	51.34%	51.09%	47.20%	-3.89	★
Combination 10	31.39%	29.68%	23.36%	**-6.32⁺⁺**	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	58.66%	65.02%	+6.36⁺	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	59.04%	62.08%	+3.04⁺	★★
Lead Screening in Children					
Lead Screening in Children	74.21%	40.63%	43.33%	+2.70	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	54.63%	58.39%	+3.76⁺	★★★
Ages 12 to 17 Years	—	44.47%	47.20%	+2.73⁺	★★
Ages 18 to 21 Years	—	23.41%	23.31%	-0.10	★★
Total	—	45.88%	48.46%	+2.58⁺	★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	81.75%	77.86%	75.91%	-1.95	★★
Combination 2 (Meningococcal, Tdap, HPV)	30.90%	29.68%	28.47%	-1.21	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	49.12%	40.70%	46.97%	+6.27⁺	★★★★
Continuation and Maintenance Phase	59.30%	54.96%	58.26%	+3.30	★★★★
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	53.49%	53.84%	52.46%	-1.38	★★★
Ages 21 to 24 Years	61.32%	61.89%	62.53%	+0.64	★★★
Total	57.22%	57.84%	57.54%	-0.30	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	59.85%	56.69%	55.06%	-1.63	★★
Breast Cancer Screening					
Breast Cancer Screening	56.20%	53.67%	54.65%	+0.98	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	73.17%	73.12%	70.38%	**-2.74⁺⁺**	★★
Ages 45 to 64 Years	83.28%	82.20%	80.64%	**-1.56⁺⁺**	★★
Ages 65 Years and Older	72.67%	72.92%	72.24%	-0.68	★
Total	76.67%	76.07%	73.68%	**-2.39⁺⁺**	★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	61.39%	62.45%	72.09%	+9.64⁺	★★★
Ages 18 to 64 Years	39.96%	42.27%	43.48%	+1.21	★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	50.05%	48.74%	58.28%	+9.54⁺	★★★
Appropriate Testing for Pharyngitis [4]					
Ages 3 to 17 Years	81.62%	79.14%	79.96%	+0.82	★★★
Ages 18 to 64 Years	67.58%	67.38%	66.43%	-0.95	★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	76.36%	73.13%	73.79%	+0.66	★★★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	90.52%	93.42%	91.63%	**-1.79⁺⁺**	★★
Ages 18 to 64 Years	79.90%	85.30%	83.56%	**-1.74⁺⁺**	★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	86.88%	89.74%	88.75%	**-0.99⁺⁺**	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	65.21%	60.83%	66.83%	+6.00	★
Counseling for Nutrition—Total	53.53%	52.55%	57.32%	+4.77	★
Counseling for Physical Activity—Total	53.77%	52.31%	56.59%	+4.28	★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care [4]	78.59%	77.86%	71.86%	-6.00	★
Postpartum Care	70.32%	67.40%	75.96%	+8.56⁺	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)**	56.45%	54.74%	58.64%	+3.90	★
HbA1c Control (<8.0%)	37.71%	38.20%	34.79%	-3.41	★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	54.74%	50.61%	52.55%	+1.94	★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	50.85%	43.31%	47.69%	+4.38	★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	29.11%	30.99%	+1.88+	★★
Ages 65 to 74 Years	—	42.42%	20.63%	**-21.79++**	★
Ages 75 to 85 Years	—	NA	NA	NC	NC
Total	—	29.22%	30.94%	+1.72+	★★
Asthma Medication Ratio					
Total	53.48%	54.64%	54.48%	-0.16	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	45.26%	46.47%	+1.21	★
Antidepressant Medication Management					
Effective Acute Phase Treatment	63.95%	68.64%	69.22%	+0.58	★★★★
Effective Continuation Phase Treatment	48.85%	52.44%	54.25%	+1.81+	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.61%	77.64%	79.13%	+1.49	★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	60.37%	65.00%	64.78%	-0.22	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	51.11%	65.96%	69.57%	+3.61	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	71.26%	65.14%	64.81%	-0.33	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
White	64.38%	68.31%	69.28%	+0.97	NC
Black or African American	20.63%	21.23%	21.16%	-0.07	NC
American Indian or Alaska Native	0.55%	1.06%	1.05%	-0.01	NC
Asian	0.80%	0.69%	1.08%	+0.39	NC
Native Hawaiian and Other Pacific Islander	0.09%	0.11%	0.12%	+0.01	NC
Some Other Race	6.06%	0.41%	6.76%	+6.35	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Unknown	7.48%	8.19%	0.56%	-7.63	NC
Declined	0.00%	0.00%	0.00%	0.00	NC
Ethnicity Reporting Category: Hispanic or Latino	6.06%	0.41%	6.32%	+5.91	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	52.87%	47.65%	99.08%	+51.43	NC
Spoken Language Preferred for Health Care—Non-English	0.40%	0.35%	0.92%	+0.57	NC
Spoken Language Preferred for Health Care—Unknown	46.73%	52.00%	0.00%	-52.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	0.00%	0.00%	98.97%	+98.97	NC
Language Preferred for Written Materials—Non-English	0.00%	0.00%	0.92%	+0.92	NC

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Language Preferred for Written Materials—Unknown	100.00%	100.00%	0.11%	-99.89	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care					
*ED Visits—Total**	620.64	667.06	675.09	+8.03	★
Outpatient Visits—Total	5,373.84	8,195.79	8,194.31	-1.48	NC
Inpatient Utilization—General Hospital/Acute Care					
Discharges—Total Inpatient—Total All Ages	99.72	88.23	77.31	-10.92	NC
Average Length of Stay—Total Inpatient—Total All Ages	3.87	4.21	4.27	+0.06	NC
Discharges—Maternity—Total All Ages	31.32	6.01	24.60	-1.41	NC
Average Length of Stay—Maternity—Total All Ages	1.69	1.71	1.67	-0.04	NC
Discharges—Surgery—Total All Ages	24.84	21.1	19.51	-1.59	NC
Average Length of Stay—Surgery—Total All Ages	6	7	6.86	-0.14	NC
Discharges—Medicine—Total All Ages	51.36	47.09	38.65	-8.44	NC
Average Length of Stay—Medicine—Total All Ages	3.86	4.02	4.26	+0.24	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	14.77%	14.19%	14.32%	+0.13	★★★★
Multiple Pharmacies	2.60%	2.13%	1.74%	-0.39	★★★
Multiple Prescribers and Multiple Pharmacies	1.21%	1.21%	0.91%	-0.30	★★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.65%	2.43%	1.33%	-1.10[+]	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	12.40%	7.22%	6.41%	-0.81[+]	★★
At Least 31 Days Covered—Total	6.36%	5.20%	4.60%	-0.60[+]	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	9.63%	9.60%	9.56%	-0.04	★★★
*Expected Readmissions—Total**	9.76%	9.71%	9.63%	-0.08	★★★
*O/E Ratio—Total**	0.99	0.9891	0.9936	0.00	★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]HEDIS MY 2022 Performance Levels were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2021 benchmark.
[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2022 or MY 2021–MY 2022 Comparisons provided for these measures are for information only.
[4] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2022 and prior years be considered with caution.
** For this indicator, a lower rate indicates better performance.*
— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
HEDIS MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table B-5—MER Trend Table

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	62.53%	54.26%	58.88%	+4.62	★★
Combination 7	56.20%	45.01%	52.31%	+7.30+	★★
Combination 10	32.85%	23.36%	25.30%	+1.94	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	60.85%	55.37%	-5.48++	★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	61.93%	59.29%	-2.64++	★
Lead Screening in Children					
Lead Screening in Children	73.87%	56.36%	55.72%	-0.64	★★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	58.18%	59.96%	+1.78+	★★★
Ages 12 to 17 Years	—	49.86%	51.05%	+1.19+	★★★
Ages 18 to 21 Years	—	27.39%	27.32%	-0.07	★★★
Total	—	50.75%	51.78%	+1.03+	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	82.73%	73.97%	78.59%	+4.62	★★★
Combination 2 (Meningococcal, Tdap, HPV)	36.50%	32.60%	27.49%	-5.11	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	44.59%	39.12%	39.94%	+0.82	★★★
Continuation and Maintenance Phase	55.18%	46.75%	40.66%	-6.09	★
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	55.53%	55.97%	61.07%	+5.10+	★★★★
Ages 21 to 24 Years	62.83%	64.36%	70.85%	+6.49+	★★★★★
Total	58.84%	59.89%	65.64%	+5.75+	★★★★
Cervical Cancer Screening					
Cervical Cancer Screening	59.41%	56.83%	60.34%	+3.51	★★★
Breast Cancer Screening					
Breast Cancer Screening	56.65%	50.97%	53.52%	+2.55+	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	76.20%	76.87%	74.69%	-2.18++	★★★
Ages 45 to 64 Years	84.67%	85.06%	83.70%	-1.36++	★★★
Ages 65 Years and Older	88.91%	88.07%	88.39%	+0.32	★★★
Total	79.18%	79.82%	77.94%	-1.88++	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	60.82%	65.46%	68.23%	+2.77	★★★
Ages 18 to 64 Years	39.00%	46.01%	40.18%	-5.83++	★★
Ages 65 Years And Older	31.25%	55.56%	40.86%	-14.70	★★
Total	50.08%	52.27%	55.30%	+3.03+	★★★
Appropriate Testing for Pharyngitis [4]					
Ages 3 to 17 Years	77.32%	71.61%	72.53%	+0.92	★★
Ages 18 to 64 Years	60.88%	56.54%	56.44%	-0.10	★★
Ages 65 Years And Older	NA	NA	21.21%	NC	★★★
Total	71.39%	64.04%	65.57%	+1.53+	★★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	91.71%	94.17%	92.54%	-1.63++	★★
Ages 18 to 64 Years	78.27%	82.61%	81.88%	-0.73	★★★
Ages 65 Years And Older	88.33%	86.42%	66.98%	-19.44++	★★
Total	87.84%	89.89%	89.23%	-0.66++	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	78.59%	72.99%	81.02%	+8.03+	★★★
Counseling for Nutrition—Total	69.83%	65.45%	69.34%	+3.89	★★
Counseling for Physical Activity—Total	68.13%	64.72%	68.86%	+4.14	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care [4]	79.08%	74.70%	74.45%	-0.25	★
Postpartum Care	67.88%	73.97%	75.91%	+1.94	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)**	44.04%	52.07%	38.93%	-13.14+	★★★
HbA1c Control (<8.0%)	47.45%	40.63%	54.99%	+14.36+	★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	50.17%	51.34%	55.23%	+3.89	★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	56.45%	55.72%	67.88%	+12.16+	★★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	30.15%	39.26%	+9.11+	★★★
Ages 65 to 74 Years	—	23.50%	34.38%	+10.88+	★★
Ages 75 to 85 Years	—	23.60%	29.30%	+5.70	★★
Total	—	29.61%	38.78%	+9.17+	★★★
Asthma Medication Ratio					
Total	60.15%	58.80%	61.16%	+2.36+	★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	48.91%	62.77%	+13.86+	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	50.48%	61.75%	72.10%	+10.35+	★★★★★
Effective Continuation Phase Treatment	33.33%	46.38%	69.38%	+23.00+	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.52%	81.01%	83.41%	+2.40+	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	61.17%	66.28%	75.84%	+9.56+	★★★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	61.90%	62.50%	75.34%	+12.84	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	68.04%	70.36%	64.90%	-5.46++	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
White	59.95%	65.87%	61.54%	-4.33	NC
Black or African American	22.36%	23.86%	22.52%	-1.34	NC
American Indian or Alaska Native	0.48%	0.88%	0.86%	-0.02	NC
Asian	2.43%	0.83%	1.16%	+0.33	NC
Native Hawaiian and Other Pacific Islander	0.08%	0.10%	0.09%	-0.01	NC
Some Other Race	0.00%	0.00%	6.06%	+6.06	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Unknown	14.70%	8.46%	7.27%	-1.19	NC
Declined	0.00%	0.00%	0.50%	+0.50	NC
Ethnicity Reporting Category: Hispanic or Latino	0.00%	0.00%	0.01%	+0.01	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.48%	98.39%	97.36%	-1.03	NC
Spoken Language Preferred for Health Care—Non-English	0.67%	0.68%	1.57%	+0.89	NC
Spoken Language Preferred for Health Care—Unknown	0.84%	0.93%	1.07%	+0.14	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	98.48%	98.39%	97.36%	-1.03	NC
Language Preferred for Written Materials—Non-English	0.67%	0.68%	1.57%	+0.89	NC

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Language Preferred for Written Materials—Unknown	0.84%	0.93%	1.07%	+0.14	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	98.48%	96.75%	97.36%	+0.61	NC
Other Language Needs—Non-English	0.67%	0.65%	1.57%	+0.92	NC
Other Language Needs—Unknown	0.84%	2.60%	1.07%	-1.53	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care					
*ED Visits—Total**	546.48	575.66	625.72	+50.06	★
Outpatient Visits—Total	4,772.76	5,124.16	4,535.66	-588.50	NC
Inpatient Utilization—General Hospital/Acute Care					
Discharges—Total Inpatient—Total All Ages	80.04	73.64	70.50	-3.14	NC
Average Length of Stay—Total Inpatient—Total All Ages	4.3	4.78	4.96	+0.18	NC
Discharges—Maternity—Total All Ages	31.56	25.68	23.73	-1.95	NC
Average Length of Stay—Maternity—Total All Ages	2.67	2.76	2.71	-0.05	NC
Discharges—Surgery—Total All Ages	18.24	16.75	13.14	-3.61	NC
Average Length of Stay—Surgery—Total All Ages	7.18	8.15	7.96	-0.19	NC
Discharges—Medicine—Total All Ages	39	38.04	39.75	+1.71	NC
Average Length of Stay—Medicine—Total All Ages	3.91	4.3	4.96	+0.66	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	14.84%	14.26%	13.18%	-1.08^{+}	★★★★
Multiple Pharmacies	3.78%	1.94%	3.37%	**+1.43^{++}**	★★
Multiple Prescribers and Multiple Pharmacies	2.59%	1.16%	1.55%	**+0.39^{++}**	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.65%	1.98%	1.56%	-0.42^{+}	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	9.38%	8.04%	16.04%	**+8.00^{++}**	★
At Least 31 Days Covered—Total	5.91%	5.51%	9.27%	**+3.76^{++}**	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	8.60%	8.43%	10.85%	**+2.42^{++}**	★
*Expected Readmissions—Total**	9.60%	9.53%	10.47%	**+0.94^{++}**	★
*O/E Ratio—Total**	0.90	0.8844	1.0361	**+0.16^{++}**	★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2020–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.
[2]HEDIS MY 2022 Performance Levels were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2021 benchmark.
[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2022 or MY 2021–MY 2022 Comparisons provided for these measures are for information only.
[4] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2022 and prior years be considered with caution.
** For this indicator, a lower rate indicates better performance.*
— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.
HEDIS MY 2022 Performance Levels represent the following percentile comparisons:
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Table B-6—MOL Trend Table

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	67.15%	54.83%	57.18%	+2.35	★
Combination 7	58.64%	46.38%	48.91%	+2.53	★
Combination 10	33.82%	26.33%	23.84%	-2.49	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	55.95%	60.34%	+4.39^{+}	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	60.53%	62.30%	+1.77^{+}	★★
Lead Screening in Children					
Lead Screening in Children	72.14%	59.61%	57.66%	-1.95	★★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	59.60%	59.81%	+0.21	★★★
Ages 12 to 17 Years	—	52.34%	52.58%	+0.24	★★★
Ages 18 to 21 Years	—	31.90%	30.90%	**-1.00^{++}**	★★★
Total	—	52.26%	52.05%	-0.21	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	83.70%	77.32%	77.09%	-0.23	★★
Combination 2 (Meningococcal, Tdap, HPV)	42.34%	32.54%	29.88%	**-2.66^{++}**	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	51.67%	46.10%	43.84%	-2.26	★★★
Continuation and Maintenance Phase	65.49%	57.07%	56.28%	-0.79	★★★
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	59.09%	62.05%	62.27%	+0.22	★★★★
Ages 21 to 24 Years	65.40%	65.63%	67.89%	+2.26^{+}	★★★★
Total	61.79%	63.67%	64.89%	+1.22^{+}	★★★★
Cervical Cancer Screening					
Cervical Cancer Screening	63.99%	57.21%	59.37%	+2.16	★★★
Breast Cancer Screening					
Breast Cancer Screening	55.52%	51.37%	53.48%	+2.11^{+}	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	75.54%	76.83%	74.44%	**-2.39^{++}**	★★★
Ages 45 to 64 Years	85.30%	85.37%	84.26%	**-1.11^{++}**	★★★
Ages 65 Years and Older	90.28%	91.58%	91.93%	+0.35	★★★★
Total	79.57%	80.21%	78.22%	**-1.99^{++}**	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	58.59%	64.02%	60.54%	**-3.48^{++}**	★★
Ages 18 to 64 Years	38.65%	46.11%	37.83%	**-8.28^{++}**	★
Ages 65 Years And Older	22.73%	34.09%	27.16%	-6.93	★
Total	48.76%	52.23%	51.01%	-1.22	★★
Appropriate Testing for Pharyngitis [4]					
Ages 3 to 17 Years	70.08%	61.07%	64.87%	+3.80^{+}	★
Ages 18 to 64 Years	52.12%	48.19%	50.69%	+2.50^{+}	★
Ages 65 Years And Older	24.00%	26.32%	25.00%	-1.32	★★★
Total	63.70%	54.42%	58.85%	+4.43^{+}	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	89.18%	92.82%	91.45%	**-1.37^{++}**	★★
Ages 18 to 64 Years	76.95%	79.99%	79.77%	-0.22	★★
Ages 65 Years And Older	61.31%	73.11%	65.98%	-7.13	★★
Total	85.63%	88.38%	88.19%	-0.19	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	76.89%	75.67%	78.10%	+2.43	★★
Counseling for Nutrition—Total	70.80%	71.29%	69.59%	-1.70	★★
Counseling for Physical Activity—Total	67.64%	68.13%	68.37%	+0.24	★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care [4]	81.27%	78.35%	81.02%	+2.67	★
Postpartum Care	70.32%	70.07%	71.53%	+1.46	★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)**	44.77%	39.90%	41.85%	+1.95	★★
HbA1c Control (<8.0%)	43.31%	51.82%	50.61%	-1.21	★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	53.28%	57.18%	53.53%	-3.65	★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	56.93%	62.77%	67.64%	+4.87	★★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	27.62%	28.90%	+1.28+	★★
Ages 65 to 74 Years	—	30.61%	31.82%	+1.21	★★
Ages 75 to 85 Years	—	31.92%	26.87%	-5.05	★
Total	—	27.91%	29.07%	+1.16+	★★
Asthma Medication Ratio					
Total	52.96%	54.32%	55.51%	+1.19	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	55.96%	63.26%	+7.30+	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	61.61%	64.51%	66.20%	+1.69+	★★★★
Effective Continuation Phase Treatment	43.83%	47.25%	48.69%	+1.44	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.55%	80.71%	81.31%	+0.60	★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	62.18%	64.42%	64.49%	+0.07	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	67.27%	64.36%	71.28%	+6.92	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	71.35%	65.79%	66.14%	+0.35	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
White	45.74%	46.75%	41.55%	-5.20	NC
Black or African American	34.04%	34.09%	27.75%	-6.34	NC
American Indian or Alaska Native	0.27%	0.36%	0.33%	-0.03	NC
Asian	0.30%	0.24%	0.16%	-0.08	NC
Native Hawaiian and Other Pacific Islander	0.00%	0.00%	0.00%	0.00	NC
Some Other Race	0.00%	0.00%	0.00%	0.00	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Unknown	19.64%	18.56%	30.21%	+11.65	NC
Declined	0.00%	0.00%	0.00%	0.00	NC
Ethnicity Reporting Category: Hispanic or Latino	6.92%	5.99%	5.03%	-0.96	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	98.51%	98.47%	98.33%	-0.14	NC
Spoken Language Preferred for Health Care—Non-English	1.47%	1.51%	1.65%	+0.14	NC
Spoken Language Preferred for Health Care—Unknown	0.02%	0.02%	0.02%	0.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	98.51%	98.47%	98.33%	-0.14	NC
Language Preferred for Written Materials—Non-English	1.47%	1.51%	1.65%	+0.14	NC

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Language Preferred for Written Materials—Unknown	0.02%	0.02%	0.02%	0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	98.51%	98.47%	98.33%	-0.14	NC
Other Language Needs—Non-English	1.47%	1.51%	1.65%	+0.14	NC
Other Language Needs—Unknown	0.02%	0.02%	0.02%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care					
*ED Visits—Total**	564.84	593.4	588.66	-4.74	★★
Outpatient Visits—Total	4,080.84	4,559.05	4,350.58	-208.47	NC
Inpatient Utilization—General Hospital/Acute Care					
Discharges—Total Inpatient—Total All Ages	71.88	80.46	65.87	-14.59	NC
Average Length of Stay—Total Inpatient—Total All Ages	5.13	5.08	5.15	+0.07	NC
Discharges—Maternity—Total All Ages	29.28	27.53	25.25	-2.28	NC
Average Length of Stay—Maternity—Total All Ages	2.83	2.83	2.91	+0.08	NC
Discharges—Surgery—Total All Ages	16.2	17.38	14.50	-2.88	NC
Average Length of Stay—Surgery—Total All Ages	9.18	9.16	9.84	+0.68	NC
Discharges—Medicine—Total All Ages	34.32	42.66	32.52	-10.14	NC
Average Length of Stay—Medicine—Total All Ages	4.65	4.49	4.35	-0.14	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	13.36%	13.12%	14.44%	**+1.32⁺⁺**	★★★★
Multiple Pharmacies	2.75%	2.11%	1.98%	-0.13	★★★
Multiple Prescribers and Multiple Pharmacies	1.70%	1.43%	1.34%	-0.09	★★★
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.15%	6.68%	1.40%	-5.28⁺	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	9.82%	19.58%	11.66%	-7.92⁺	★
At Least 31 Days Covered—Total	6.95%	12.07%	5.97%	-6.10⁺	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	9.43%	8.98%	8.82%	-0.16	★★★
*Expected Readmissions—Total**	9.90%	9.76%	9.65%	-0.11	★★★
*O/E Ratio—Total**	0.95	0.9205	0.9145	-0.01	★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2022 Performance Levels were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2021 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2022 or MY 2021–MY 2022 Comparisons provided for these measures are for information only.

[4] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2022 and prior years be considered with caution.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

HEDIS MY 2022 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table B-7—PRI Trend Table

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	74.70%	61.26%	63.50%	+2.24	★★★
Combination 7	65.94%	52.72%	55.72%	+3.00	★★★
Combination 10	47.93%	35.68%	32.85%	-2.83	★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	59.18%	53.15%	**-6.03⁺⁺**	★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	65.58%	59.86%	**-5.72⁺⁺**	★
Lead Screening in Children					
Lead Screening in Children	78.35%	56.02%	60.83%	+4.81	★★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	60.53%	61.72%	+1.19⁺	★★★
Ages 12 to 17 Years	—	51.89%	51.71%	-0.18	★★★
Ages 18 to 21 Years	—	30.06%	29.23%	-0.83	★★★
Total	—	52.67%	52.87%	+0.20	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	87.59%	81.51%	77.99%	-3.52	★★
Combination 2 (Meningococcal, Tdap, HPV)	45.99%	36.74%	33.60%	-3.14	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	37.07%	31.21%	34.74%	+3.53	★
Continuation and Maintenance Phase	42.59%	38.21%	35.45%	-2.76	★
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	58.78%	60.52%	57.75%	**-2.77⁺⁺**	★★★
Ages 21 to 24 Years	63.95%	66.59%	65.55%	-1.04	★★★
Total	61.05%	63.39%	61.47%	**-1.92⁺⁺**	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	67.88%	63.99%	61.31%	-2.68	★★★
Breast Cancer Screening					
Breast Cancer Screening	64.51%	56.52%	53.81%	**-2.71⁺⁺**	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	76.55%	73.78%	70.74%	**-3.04⁺⁺**	★★
Ages 45 to 64 Years	85.47%	83.17%	81.44%	**-1.73⁺⁺**	★★
Ages 65 Years and Older	91.77%	90.26%	89.64%	-0.62	★★★★
Total	80.06%	77.22%	74.58%	**-2.64⁺⁺**	★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	71.56%	72.04%	77.98%	+5.94⁺	★★★★
Ages 18 to 64 Years	48.74%	52.75%	53.86%	+1.11	★★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	59.51%	58.50%	66.36%	+7.86⁺	★★★★
Appropriate Testing for Pharyngitis [4]					
Ages 3 to 17 Years	81.08%	71.38%	75.37%	+3.99⁺	★★
Ages 18 to 64 Years	68.19%	59.77%	62.66%	+2.89	★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	76.32%	64.77%	68.84%	+4.07⁺	★★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	95.18%	96.10%	95.72%	-0.38	★★★
Ages 18 to 64 Years	87.57%	88.79%	90.21%	+1.42⁺	★★★★
Ages 65 Years And Older	89.74%	87.50%	90.28%	+2.78	★★★★
Total	93.04%	93.48%	94.01%	+0.53	★★★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	90.02%	91.97%	88.56%	-3.41	★★★★★
Counseling for Nutrition—Total	81.75%	83.70%	80.29%	-3.41	★★★
Counseling for Physical Activity—Total	80.29%	82.73%	79.32%	-3.41	★★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care [4]	86.37%	79.56%	80.78%	+1.22	★
Postpartum Care	79.56%	75.91%	80.05%	+4.14	★★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)**	28.47%	34.31%	30.41%	-3.90	★★★★★
HbA1c Control (<8.0%)	60.58%	55.72%	57.66%	+1.94	★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	63.02%	61.31%	54.48%	-6.83⁺⁺	★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	75.91%	69.59%	68.61%	-0.98	★★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	34.91%	35.93%	+1.02	★★★
Ages 65 to 74 Years	—	34.09%	39.29%	+5.20	★★★
Ages 75 to 85 Years	—	29.77%	41.40%	+11.63⁺	★★★
Total	—	34.79%	36.20%	+1.41⁺	★★★
Asthma Medication Ratio					
Total	73.36%	62.79%	65.61%	+2.82⁺	★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	66.42%	73.24%	+6.82⁺	★★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	62.76%	68.78%	78.81%	+10.03⁺	★★★★★
Effective Continuation Phase Treatment	45.30%	51.45%	66.20%	+14.75⁺	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.64%	83.40%	78.57%	-4.83⁺⁺	★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	61.00%	72.60%	64.94%	-7.66	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	72.27%	66.79%	64.13%	-2.66	★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
White	59.62%	59.24%	59.70%	+0.46	NC
Black or African American	15.20%	26.40%	25.99%	-0.41	NC
American Indian or Alaska Native	0.55%	0.78%	0.82%	+0.04	NC
Asian	0.97%	0.92%	0.94%	+0.02	NC
Native Hawaiian and Other Pacific Islander	0.08%	0.11%	0.12%	+0.01	NC
Some Other Race	0.00%	0.01%	7.66%	+7.65	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Unknown	23.58%	12.09%	4.76%	-7.33	NC
Declined	0.00%	0.46%	0.00%	-0.46	NC
Ethnicity Reporting Category: Hispanic or Latino	11.27%	0.62%	8.37%	+7.75	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	0.00%	1.09%	0.00%	-1.09	NC
Spoken Language Preferred for Health Care—Non-English	0.00%	0.00%	0.00%	0.00	NC
Spoken Language Preferred for Health Care—Unknown	100.00%	98.91%	100.00%	+1.09	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	0.00%	1.09%	0.00%	-1.09	NC
Language Preferred for Written Materials—Non-English	0.00%	0.00%	0.00%	0.00	NC

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Language Preferred for Written Materials—Unknown	100.00%	98.91%	100.00%	+1.09	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	0.00%	1.09%	0.00%	-1.09	NC
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	100.00%	98.91%	100.00%	+1.09	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care					
*ED Visits—Total**	594.48	626.26	621.26	-5.00	★
Outpatient Visits—Total	3,533.04	3,822.72	4,752.17	+929.45	NC
Inpatient Utilization—General Hospital/Acute Care					
Discharges—Total Inpatient—Total All Ages	64.2	69.42	58.89	-10.53	NC
Average Length of Stay—Total Inpatient—Total All Ages	4.27	4.72	5.01	+0.29	NC
Discharges—Maternity—Total All Ages	32.64	25.85	24.48	-1.37	NC
Average Length of Stay—Maternity—Total All Ages	3.01	2.88	2.85	-0.03	NC
Discharges—Surgery—Total All Ages	15.6	16.37	13.82	-2.55	NC
Average Length of Stay—Surgery—Total All Ages	6.23	7.59	8.53	+0.94	NC
Discharges—Medicine—Total All Ages	25.56	33.92	26.77	-7.15	NC
Average Length of Stay—Medicine—Total All Ages	4.21	4.38	4.68	+0.30	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	18.70%	17.20%	18.94%	**+1.74**$^{++}$	★★
Multiple Pharmacies	2.23%	2.38%	1.68%	-0.70^{+}	★★★
Multiple Prescribers and Multiple Pharmacies	1.21%	1.34%	0.99%	-0.35	★★★
se of Opioids at High Dosage					
*Use of Opioids at High Dosage**	3.04%	11.32%	1.71%	-9.61^{+}	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	10.85%	14.30%	13.11%	-1.19^{+}	★
At Least 31 Days Covered—Total	5.88%	8.23%	6.66%	-1.57^{+}	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	7.75%	8.51%	8.61%	+0.10	★★★★
*Expected Readmissions—Total**	9.61%	9.75%	9.64%	-0.11	★★★
*O/E Ratio—Total**	0.81	0.8721	0.8936	+0.02	★★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2020–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2022 Performance Levels were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2021 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2022 or MY 2021–MY 2022 Comparisons provided for these measures are for information only.

[4] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2022 and prior years be considered with caution.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2022 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table B-8—UNI Trend Table

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	61.80%	52.40%	54.42%	+2.02[+]	★
Combination 7	54.74%	43.81%	45.21%	+1.40	★
Combination 10	29.68%	24.91%	22.19%	**-2.72[++]**	★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	57.52%	63.74%	+6.22[+]	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	58.08%	60.54%	+2.46[+]	★★
Lead Screening in Children					
Lead Screening in Children	74.70%	58.88%	59.12%	+0.24	★★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	57.53%	57.05%	-0.48	★★★
Ages 12 to 17 Years	—	50.23%	50.53%	+0.30	★★
Ages 18 to 21 Years	—	32.09%	30.71%	**-1.38[++]**	★★★
Total	—	50.60%	50.04%	**-0.56[++]**	★★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	80.78%	78.83%	76.89%	-1.94	★★
Combination 2 (Meningococcal, Tdap, HPV)	38.20%	34.31%	31.14%	-3.17	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	41.20%	38.96%	44.45%	+5.49[+]	★★★★
Continuation and Maintenance Phase	54.09%	56.71%	51.35%	-5.36	★★
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	59.85%	60.01%	59.47%	-0.54	★★★
Ages 21 to 24 Years	64.95%	65.18%	63.50%	-1.68	★★★
Total	62.06%	62.36%	61.33%	-1.03	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	57.66%	58.88%	58.88%	0.00	★★★
Breast Cancer Screening					
Breast Cancer Screening	54.30%	51.15%	53.45%	+2.30[+]	★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	73.73%	75.44%	73.00%	**-2.44[++]**	★★
Ages 45 to 64 Years	84.72%	85.50%	84.17%	**-1.33[++]**	★★★
Ages 65 Years and Older	88.25%	91.11%	90.27%	-0.84	★★★★
Total	77.79%	79.02%	77.02%	**-2.00[++]**	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	60.54%	62.35%	60.75%	-1.60	★★
Ages 18 to 64 Years	38.84%	43.88%	36.89%	**-6.99[++]**	★
Ages 65 Years And Older	31.25%	NA	27.27%	NC	★
Total	49.38%	50.25%	50.05%	-0.20	★★
Appropriate Testing for Pharyngitis [4]					
Ages 3 to 17 Years	73.31%	62.16%	62.95%	+0.79	★
Ages 18 to 64 Years	51.63%	41.68%	42.32%	+0.64	★
Ages 65 Years And Older	NA	NA	17.31%	NC	★★★
Total	65.10%	50.73%	53.32%	+2.59[+]	★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	91.43%	94.24%	91.92%	**-2.32[++]**	★★
Ages 18 to 64 Years	75.01%	77.10%	76.01%	-1.09	★★
Ages 65 Years And Older	67.80%	65.85%	71.70%	+5.85	★★
Total	86.75%	88.40%	87.36%	**-1.04[++]**	★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	82.48%	79.56%	83.94%	+4.38	★★★
Counseling for Nutrition—Total	73.72%	74.94%	73.97%	-0.97	★★★
Counseling for Physical Activity—Total	71.29%	74.94%	70.56%	-4.38	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care [4]	78.83%	82.48%	77.37%	-5.11	★
Postpartum Care	71.78%	74.70%	74.70%	0.00	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)**	34.79%	33.09%	33.09%	0.00	★★★★
HbA1c Control (<8.0%)	54.26%	56.93%	59.12%	+2.19	★★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	55.23%	55.47%	56.93%	+1.46	★★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	63.75%	67.15%	75.18%	+8.03+	★★★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	37.55%	40.62%	+3.07+	★★★★
Ages 65 to 74 Years	—	43.35%	51.15%	+7.80+	★★★★
Ages 75 to 85 Years	—	47.69%	57.46%	+9.77	★★★★★
Total	—	37.87%	41.30%	+3.43+	★★★★
Asthma Medication Ratio					
Total	61.08%	59.94%	62.79%	+2.85+	★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	64.72%	65.45%	+0.73	★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	54.48%	61.65%	61.19%	-0.46	★★★
Effective Continuation Phase Treatment	38.21%	45.20%	43.28%	-1.92	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.12%	84.31%	85.09%	+0.78	★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	61.61%	65.26%	65.57%	+0.31	★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	67.86%	66.04%	65.96%	-0.08	★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.78%	61.53%	60.59%	-0.94	★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
White	50.57%	55.96%	54.52%	-1.44	NC
Black or African American	29.76%	30.84%	30.12%	-0.72	NC
American Indian or Alaska Native	0.30%	0.60%	0.60%	0.00	NC
Asian	3.38%	1.79%	1.76%	-0.03	NC
Native Hawaiian and Other Pacific Islander	0.08%	0.10%	0.11%	+0.01	NC
Some Other Race	0.00%	0.00%	0.00%	0.00	NC
Two or More Races	0.00%	0.00%	0.00%	0.00	NC
Unknown	15.90%	10.70%	12.90%	+2.20	NC
Declined	0.00%	0.00%	0.00%	0.00	NC
Ethnicity Reporting Category: Hispanic or Latino	6.34%	1.23%	0.92%	-0.31	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	96.13%	96.20%	95.91%	-0.29	NC
Spoken Language Preferred for Health Care—Non-English	3.86%	3.80%	3.92%	+0.12	NC
Spoken Language Preferred for Health Care—Unknown	0.01%	0.00%	0.17%	+0.17	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	96.13%	96.20%	95.91%	-0.29	NC
Language Preferred for Written Materials—Non-English	3.86%	3.80%	3.92%	+0.12	NC

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Language Preferred for Written Materials—Unknown	0.01%	0.00%	0.17%	+0.17	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	96.13%	96.20%	95.91%	-0.29	NC
Other Language Needs—Non-English	3.86%	3.80%	3.92%	+0.12	NC
Other Language Needs—Unknown	0.01%	0.00%	0.17%	+0.17	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care					
*ED Visits—Total**	552.12	592.23	613.40	+21.17	★★
Outpatient Visits—Total	3,782.28	4,265.71	4,352.40	+86.69	NC
Inpatient Utilization—General Hospital/Acute Care					
Discharges—Total Inpatient—Total All Ages	63.48	58.78	57.21	-1.57	NC
Average Length of Stay—Total Inpatient—Total All Ages	4.7	5.11	5.30	+0.19	NC
Discharges—Maternity—Total All Ages	27.24	22.13	21.89	-0.24	NC
Average Length of Stay—Maternity—Total All Ages	2.46	2.46	2.43	-0.03	NC
Discharges—Surgery—Total All Ages	14.28	14.22	13.76	-0.46	NC
Average Length of Stay—Surgery—Total All Ages	8.02	8.56	9.30	+0.74	NC
Discharges—Medicine—Total All Ages	28.92	27.83	26.73	-1.10	NC
Average Length of Stay—Medicine—Total All Ages	4.61	4.94	5.04	+0.10	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	14.38%	15.22%	15.70%	+0.48	★★★
Multiple Pharmacies	2.00%	1.70%	1.64%	-0.06	★★★
Multiple Prescribers and Multiple Pharmacies	1.17%	1.15%	1.11%	-0.04	★★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	2.90%	2.76%	1.95%	-0.81[+]	★★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	9.87%	9.06%	8.96%	-0.10	★
At Least 31 Days Covered—Total	6.80%	6.51%	6.27%	-0.24	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	12.05%	10.76%	10.49%	-0.27	★★
*Expected Readmissions—Total**	10.77%	10.75%	10.88%	+0.13	★
*O/E Ratio—Total**	1.12	1.0007	0.9645	-0.04[+]	★★★

[1]HEDIS MY 2021 to HEDIS MY 2022 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2021–2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2022 Performance Levels were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2021 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2022 or MY 2021–MY 2021 Comparisons provided for these measures are for information only.

[4] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2022 and prior years be considered with caution.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2022 Performance Levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Table B-9—UPP Trend Table

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Child & Adolescent Care					
Childhood Immunization Status					
Combination 3	66.08%	60.69%	65.69%	+5.00	★★★
Combination 7	53.94%	50.58%	53.28%	+2.70	★★
Combination 10	39.21%	36.32%	31.39%	-4.93	★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	67.53%	70.23%	+2.70	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	67.43%	68.09%	+0.66	★★★
Lead Screening in Children					
Lead Screening in Children	74.48%	39.75%	52.07%	+12.32^{+}	★
Child and Adolescent Well-Care Visits					
Ages 3 to 11 Years	—	57.85%	56.40%	**-1.45^{++}**	★★★
Ages 12 to 17 Years	—	51.87%	50.27%	-1.60	★★
Ages 18 to 21 Years	—	23.44%	23.73%	+0.29	★★
Total	—	49.99%	48.65%	**-1.34^{++}**	★★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	80.72%	79.30%	76.40%	-2.90	★★
Combination 2 (Meningococcal, Tdap, HPV)	34.93%	34.53%	28.47%	**-6.06^{++}**	★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	50.42%	38.40%	51.91%	+13.51^{+}	★★★★★
Continuation and Maintenance Phase	62.20%	43.30%	54.62%	+11.32	★★★
Women—Adult Care					
Chlamydia Screening in Women					
Ages 16 to 20 Years	41.01%	41.06%	43.20%	+2.14	★
Ages 21 to 24 Years	49.82%	51.13%	48.69%	-2.44	★
Total	44.89%	45.73%	45.75%	+0.02	★
Cervical Cancer Screening					
Cervical Cancer Screening	58.15%	61.31%	61.80%	+0.49	★★★
Breast Cancer Screening					
Breast Cancer Screening	61.87%	59.29%	59.84%	+0.55	★★★★
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	78.29%	76.69%	75.03%	**-1.66^{++}**	★★★
Ages 45 to 64 Years	85.12%	84.68%	83.39%	**-1.29^{++}**	★★★
Ages 65 Years and Older	92.68%	95.29%	94.52%	-0.77	★★★★★
Total	81.72%	80.61%	79.06%	**-1.55^{++}**	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Ages 3 Months to 17 Years	64.64%	64.47%	78.11%	+13.64^{+}	★★★★
Ages 18 to 64 Years	36.47%	45.14%	45.85%	+0.71	★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	47.53%	50.77%	62.25%	+11.48^{+}	★★★★
Appropriate Testing for Pharyngitis [4]					
Ages 3 to 17 Years	79.18%	85.35%	85.29%	-0.06	★★★★
Ages 18 to 64 Years	71.84%	76.03%	78.52%	+2.49	★★★★★
Ages 65 Years And Older	NA	NA	NA	NC	NC
Total	76.40%	80.23%	81.70%	+1.47	★★★★★
Appropriate Treatment for Upper Respiratory Infection					
Ages 3 Months to 17 Years	91.43%	94.19%	93.17%	-1.02	★★
Ages 18 to 64 Years	83.13%	88.85%	85.01%	**-3.84^{++}**	★★★
Ages 65 Years And Older	NA	NA	68.42%	NC	★★
Total	88.72%	92.24%	90.24%	**-2.00^{++}**	★★
Obesity					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	88.08%	89.54%	92.94%	+3.40	★★★★★
Counseling for Nutrition—Total	72.99%	75.18%	75.43%	+0.25	★★★
Counseling for Physical Activity—Total	69.59%	72.02%	70.32%	-1.70	★★★
Pregnancy Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care [4]	91.24%	92.21%	92.94%	+0.73	★★★★★
Postpartum Care	87.59%	88.08%	89.29%	+1.21	★★★★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)**	29.93%	33.33%	30.17%	-3.16	★★★★★
HbA1c Control (<8.0%)	57.42%	55.47%	61.07%	+5.60	★★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	61.07%	59.61%	60.83%	+1.22	★★★★
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	78.35%	82.48%	82.00%	-0.48	★★★★★
Kidney Health Evaluation for Patients With Diabetes					
Ages 18 to 64 Years	—	34.50%	36.10%	+1.60	★★★
Ages 65 to 74 Years	—	39.38%	36.67%	-2.71	★★★
Ages 75 to 85 Years	—	35.06%	29.58%	-5.48	★★
Total	—	34.98%	35.99%	+1.01	★★★
Asthma Medication Ratio					
Total	58.42%	57.59%	57.67%	+0.08	★
Controlling High Blood Pressure					
Controlling High Blood Pressure	—	79.08%	79.08%	0.00	★★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	62.13%	64.14%	73.09%	+8.95[+]	★★★★★
Effective Continuation Phase Treatment	44.50%	46.68%	55.69%	+9.01[+]	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.06%	86.36%	86.61%	+0.25	★★★★★
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	82.35%	85.71%	73.49%	-12.22[++]	★★★★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC	NC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	84.72%	85.09%	82.69%	-2.40	★★★★★
Health Plan Diversity					
Race/Ethnicity Diversity of Membership					
White	87.12%	87.82%	89.89%	+2.07	NC
Black or African American	1.66%	1.77%	1.85%	+0.08	NC
American Indian or Alaska Native	2.67%	3.70%	3.84%	+0.14	NC
Asian	0.44%	0.28%	0.51%	+0.23	NC
Native Hawaiian and Other Pacific Islander	0.13%	0.13%	0.16%	+0.03	NC
Some Other Race	2.08%	0.19%	3.56%	+3.37	NC
Two or More Races	0.00%	0.00%	0.03%	+0.03	NC
Unknown	0.00%	0.00%	0.00%	0.00	NC
Declined	5.90%	6.11%	0.16%	-5.95	NC
Ethnicity Reporting Category: Hispanic or Latino	2.08%	0.19%	2.34%	+2.15	NC
Language Diversity of Membership					
Spoken Language Preferred for Health Care—English	99.90%	99.88%	99.86%	-0.02	NC
Spoken Language Preferred for Health Care—Non-English	0.07%	0.10%	0.12%	+0.02	NC
Spoken Language Preferred for Health Care—Unknown	0.03%	0.02%	0.02%	0.00	NC
Spoken Language Preferred for Health Care—Declined	0.00%	0.00%	0.00%	0.00	NC
Language Preferred for Written Materials—English	99.90%	99.88%	99.86%	-0.02	NC
Language Preferred for Written Materials—Non-English	0.07%	0.10%	0.12%	+0.02	NC

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Language Preferred for Written Materials—Unknown	0.03%	0.02%	0.02%	0.00	NC
Language Preferred for Written Materials—Declined	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Non-English	0.00%	0.00%	0.00%	0.00	NC
Other Language Needs—Unknown	100.00%	100.00%	100.00%	0.00	NC
Other Language Needs—Declined	0.00%	0.00%	0.00%	0.00	NC
Utilization[3]					
Ambulatory Care					
*ED Visits—Total**	514.44	581.69	603.86	+22.17	★★
Outpatient Visits—Total	3,810.48	4,127.91	3,986.58	-141.33	NC
Inpatient Utilization—General Hospital/Acute Care					
Discharges—Total Inpatient—Total All Ages	74.4	72.76	66.38	-6.38	NC
Average Length of Stay—Total Inpatient—Total All Ages	4.41	4.65	4.96	+0.31	NC
Discharges—Maternity—Total All Ages	24.12	22.01	19.11	-2.90	NC
Average Length of Stay—Maternity—Total All Ages	2.75	2.61	2.54	-0.07	NC
Discharges—Surgery—Total All Ages	21.96	21.7	19.36	-2.34	NC
Average Length of Stay—Surgery—Total All Ages	6.46	6.8	7.56	+0.76	NC
Discharges—Medicine—Total All Ages	34.56	34.58	32.61	-1.97	NC
Average Length of Stay—Medicine—Total All Ages	3.96	4.27	4.48	+0.21	NC
Use of Opioids From Multiple Providers*					
Multiple Prescribers	16.04%	17.73%	17.04%	-0.69	★★★
Multiple Pharmacies	6.41%	6.83%	6.19%	-0.64	★
Multiple Prescribers and Multiple Pharmacies	4.77%	5.17%	4.03%	-1.14	★

Measure	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022	MY 2021–MY 2022 Comparison[1]	MY 2022 Performance Level[2]
Use of Opioids at High Dosage					
*Use of Opioids at High Dosage**	3.33%	2.38%	2.42%	+0.04	★★★
Risk of Continued Opioid Use*					
At Least 15 Days Covered—Total	9.27%	7.87%	7.64%	-0.23	★★
At Least 31 Days Covered—Total	5.43%	5.30%	4.91%	-0.39	★
Plan All-Cause Readmissions					
*Observed Readmissions—Total**	9.38%	9.06%	7.69%	-1.37	★★★★★
*Expected Readmissions—Total**	9.97%	9.99%	9.82%	-0.17	★★
*O/E Ratio—Total**	0.94	0.9076	0.7834	-0.13[+]	★★★★★

[1]HEDIS MY 2022 to HEDIS MY 2021 comparisons were based on a Chi-square test of statistical significance with a p value of <0.05. MY 2021–MY 2022 Comparisons shaded green with one cross (+) indicate significant improvement from the previous year. MY 2021–MY 2022 Comparisons shaded red with two crosses (++) indicate a significant decline in performance from the previous year.

[2]HEDIS MY 2022 Performance Levels were based on comparisons of the HEDIS MY 2022 measure indicator rates to national Medicaid Quality Compass HEDIS MY 2021 benchmarks, with the exception of the Plan All-Cause Readmissions measure indicator rates, which were compared to the national Medicaid NCQA Audit Means and Percentiles HEDIS MY 2021 benchmark.

[3]Significance testing was not performed for utilization-based or health plan description measure indicator rates, and any Performance Levels for MY 2022 or MY 2021–MY 2022 Comparisons provided for these measures are for information only.

[4] Due to changes in the technical specifications for this measure, NCQA recommends trending between MY 2022 and prior years be considered with caution.

** For this indicator, a lower rate indicates better performance.*

— indicates that the rate is not presented in this report as NCQA previously recommended a break in trending for the measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

HEDIS MY 2022 Performance Levels represent the following percentile comparisons:

★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Appendix C. Performance Summary Stars

Introduction

This section presents the MHPs' performance summary stars for each measure within the following measure domains:

- Child & Adolescent Care
- Women—Adult Care
- Access to Care
- Obesity
- Living With Illness
- Utilization

Performance ratings were assigned by comparing the MHPs' HEDIS MY 2022 rates to the HEDIS MY 2021 MWA Quality Compass national Medicaid benchmarks (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*). Measures in the Health Plan Diversity domain and utilization-based measure rates were not evaluated based on comparisons to national benchmarks; however, rates for these measure indicators are presented in Appendix B. Additional details about the performance comparisons and star ratings are found in Section 2.

Child & Adolescent Care Performance Summary Stars

Table C-1—Child & Adolescent Care Performance Summary Stars (Table 1 of 3)

MHP	*Childhood Immunization Status—Combination 3*	*Childhood Immunization Status—Combination 7*	*Childhood Immunization Status—Combination 10*	*Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*	*Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*	*Lead Screening in Children*
AET	★	★	★	★	★	★
BCC	★	★	★	★★★★★	★★	★★
HAP	★	★	★	★★	★	★
MCL	★	★	★	★★★★	★★	★
MER	★★	★★	★	★★	★	★★
MOL	★	★	★	★★★	★★	★★
PRI	★★★	★★★	★★	★★	★	★★
UNI	★	★	★	★★★★	★★	★★
UPP	★★★	★★	★★	★★★★★	★★★	★

Table C-2—Child & Adolescent Care Performance Summary Stars (Table 2 of 3)

MHP	*Child and Adolescent Well-Care Visits—Ages 3 to 11 Years*	*Child and Adolescent Well-Care Visits—Ages 12 to 17 Years*	*Child and Adolescent Well-Care Visits—Ages 18 to 21 Years*	*Child and Adolescent Well-Care Visits—Total*	*Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*	*Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
AET	★★	★	★★	★★	★	★
BCC	★★★	★★	★★★	★★★	★★	★
HAP	★	★	★★	★	★	★
MCL	★★★	★★	★★	★★	★★	★
MER	★★★	★★★	★★★	★★★	★★★	★
MOL	★★★	★★★	★★★	★★★	★★	★
PRI	★★★	★★★	★★★	★★★	★★	★★
UNI	★★★	★★	★★★	★★★	★★	★★
UPP	★★★	★★	★★	★★	★★	★

Table C-3—Child & Adolescent Care Performance Summary Stars (Table 3 of 3)

MHP	*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*	*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
AET	★★★	NA
BCC	★★★★	★★★★
HAP	★	NA
MCL	★★★★	★★★★
MER	★★★	★
MOL	★★★	★★★
PRI	★	★
UNI	★★★★	★★
UPP	★★★★★	★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Women—Adult Care Performance Summary Stars

Table C-4—Women—Adult Care Performance Summary Stars

MHP	*Chlamydia Screening in Women—Ages 16 to 20 Years*	*Chlamydia Screening in Women—Ages 21 to 24 Years*	*Chlamydia Screening in Women—Total*	*Cervical Cancer Screening*	*Breast Cancer Screening*
AET	★★★★	★★★★	★★★★	★	★★
BCC	★★★★	★★★	★★★★	★★★	★★★
HAP	★★★★	★★★	★★★★	★★	★★★
MCL	★★★	★★★	★★★	★★	★★★
MER	★★★★	★★★★★	★★★★	★★★	★★★
MOL	★★★★	★★★★	★★★★	★★★	★★★
PRI	★★★	★★★	★★★	★★★	★★★
UNI	★★★	★★★	★★★	★★★	★★★
UPP	★	★	★	★★★	★★★★

Access to Care Performance Summary Stars

Table C-5—Access to Care Performance Summary Stars (Table 1 of 3)

MHP	*Adults' Access to Preventive/ Ambulatory Health Services—Ages 20 to 44 Years*	*Adults' Access to Preventive/ Ambulatory Health Services—Ages 45 to 64 Years*	*Adults' Access to Preventive/ Ambulatory Health Services—Ages 65 Years and Older*	*Adults' Access to Preventive/ Ambulatory Health Services—Total*	*Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis—Ages 3 Months to 17 Years*	*Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis—Ages 18 to 64 Years*
AET	★	★★	★★★	★	★★★★	★★
BCC	★★★	★★	★	★★★	★★	★
HAP	★	★	★★★★	★	★★	★★
MCL	★★	★★	★	★★	★★★	★★
MER	★★★	★★★	★★★	★★★	★★★	★★
MOL	★★★	★★★	★★★★	★★★	★★	★
PRI	★★	★★	★★★★	★★	★★★★	★★★★
UNI	★★	★★★	★★★★	★★★	★★	★
UPP	★★★	★★★	★★★★★	★★★	★★★★	★★★

Table C-6—Access to Care Performance Summary Stars (Table 2 of 3)

MHP	*Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis—Ages 65 Years And Older*	*Avoidance of Antibiotic Treatment for Acute Bronchitis Bronchiolitis—Total*	*Appropriate Testing for Pharyngitis—Ages 3 to 17 Years*[1]	*Appropriate Testing for Pharyngitis—Ages 18 to 64 Years*[1]	*Appropriate Testing for Pharyngitis—Ages 65 Years And Older*[1]	*Appropriate Testing for Pharyngitis—Total*[1]
AET	★	★★★	★	★	NA	★
BCC	NA	★★	★	★	NA	★
HAP	★	★	★	★★	NA	★
MCL	NA	★★★	★★★	★★★	NA	★★★
MER	★★	★★★	★★	★★	★★★	★★
MOL	★	★★	★	★	★★★	★
PRI	NA	★★★★	★★	★★★	NA	★★
UNI	★	★★	★	★	★★★	★
UPP	NA	★★★★	★★★★	★★★★★	NA	★★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

[1] *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.*

Table C-7—Access to Care Performance Summary Stars (Table 3 of 3)

MHP	*Appropriate Treatment for Upper Respiratory Infection—Ages 3 Months to 17 Years*	*Appropriate Treatment for Upper Respiratory Infection—Ages 18 to 64 Years*	*Appropriate Treatment for Upper Respiratory Infection—Ages 65 Years And Older*	*Appropriate Treatment for Upper Respiratory Infection—Total*
AET	★★	★★★	★	★★
BCC	★★	★★	NA	★★
HAP	★★	★★★	★★	★
MCL	★★	★★★	NA	★★
MER	★★	★★★	★★	★★
MOL	★★	★★	★★	★★
PRI	★★★	★★★★	★★★★	★★★★
UNI	★★	★★	★★	★
UPP	★★	★★★	★★	★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Obesity Performance Summary Stars

Table C-8—Obesity Performance Summary Stars

MHP	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
AET	★★★	★★★	★★★
BCC	★★★	★★★	★★★
HAP	★★★★	★★★	★★★
MCL	★	★	★
MER	★★★	★★	★★★
MOL	★★	★★	★★
PRI	★★★★★	★★★	★★★★
UNI	★★★	★★★	★★★
UPP	★★★★★	★★★	★★★

Pregnancy Care Performance Summary Stars

Table C-9—Pregnancy Care Performance Summary Stars

MHP	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*[1]	*Prenatal and Postpartum Care—Postpartum Care*
AET	★	★
BCC	★★★	★★
HAP	★	★
MCL	★	★★
MER	★	★★
MOL	★	★
PRI	★	★★★
UNI	★	★★
UPP	★★★★★	★★★★★

[1] *Due to changes in the technical specifications for this measure, NCQA recommends that trending between MY 2022 and prior years be considered with caution.*

Living With Illness Performance Summary Stars

Table C-10—Living With Illness Performance Summary Stars (Table 1 of 3)

MHP	*Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**	*HbA1c Control (<8.0%)*	*Eye Exam for Patients With Diabetes*	*Blood Pressure Control for Patients With Diabetes*	*Kidney Health Evaluation for Patients With Diabetes—Ages 18 to 64 Years*	*Kidney Health Evaluation for Patients With Diabetes—Ages 65 to 74 Years*
AET	★★★	★★★	★★★	★★	★	★★
BCC	★★★★	★★★★★	★★★	★★★★	★★★	★★★
HAP	★★★	★★★★	★★★★	★★★	★★★	★★★
MCL	★	★	★★★	★	★★	★
MER	★★★	★★★★	★★★	★★★★	★★★	★★
MOL	★★	★★★	★★★	★★★★	★★	★★
PRI	★★★★★	★★★★	★★★	★★★★	★★★	★★★
UNI	★★★★	★★★★★	★★★★	★★★★★	★★★★	★★★★
UPP	★★★★★	★★★★★	★★★★	★★★★★	★★★	★★★

**For this indicator, a lower rate indicates better performance.*

Table C-11—Living With Illness Performance Summary Stars (Table 2 of 3)

MHP	*Kidney Health Evaluation for Patients With Diabetes—Ages 75 to 85 Years*	*Kidney Health Evaluation for Patients With Diabetes—Total*	*Asthma Medication Ratio—Total*	*Controlling High Blood Pressure*	*Antidepressant Medication Management—Effective Acute Phase Treatment*	*Antidepressant Medication Management—Effective Continuation Phase Treatment*
AET	★	★	★	★★	★★★★	★★★★
BCC	★★★	★★★	★	★★	★★★★	★★★★
HAP	★★★	★★★	★	★★★	★★★★★	★★★★★
MCL	NA	★★	★	★	★★★★	★★★★
MER	★★	★★★	★★	★★★	★★★★★	★★★★★
MOL	★	★★	★	★★★	★★★★	★★★★
PRI	★★★	★★★	★★★	★★★★★	★★★★★	★★★★★
UNI	★★★★★	★★★★	★★	★★★★	★★★	★★★
UPP	★★	★★★	★	★★★★★	★★★★★	★★★★

NA indicates that the MHP followed the specifications, but the denominator was too small (<30) to report a valid rate.

Table C-12—Living With Illness Performance Summary Stars (Table 3 of 3)

MHP	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*Diabetes Monitoring for People With Diabetes and Schizophrenia*	*Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
AET	★★	★	NA	★★★
BCC	★★★	★★	NA	★★
HAP	★★★	★★	NA	★★
MCL	★★	★★	★★	★★★
MER	★★★★	★★★★	★★	★★★
MOL	★★★	★★	★★	★★★
PRI	★★	★★	NA	★★★
UNI	★★★★	★★	★	★★
UPP	★★★★★	★★★★	NA	★★★★★

Utilization Performance Summary Stars

Table C-13—Utilization Performance Summary Stars (Table 1 of 2)[1]

MHP	*Ambulatory Care—ED Visits—Total*	*Use of Opioids From Multiple Providers—Multiple Prescribers*	*Use of Opioids From Multiple Providers—Multiple Pharmacies*	*Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies*	*Use of Opioids at High Dosage*	*Risk of Continued Opioid Use—At Least 15 Days Covered—Total*
AET	★	★★★	★★	★★	★★★	★
BCC	★★	★★★	★★	★★	★★★★	★★
HAP	★★	★★★	★★	★★	★★★★	★
MCL	★	★★★★	★★★	★★★	★★★★	★★
MER	★	★★★★	★★	★★	★★★★	★
MOL	★★	★★★★	★★★	★★★	★★★★	★
PRI	★	★★	★★★	★★★	★★★★	★
UNI	★★	★★★	★★★	★★★	★★★★	★
UPP	★★	★★★	★	★	★★★	★★

[1]*A lower rate may indicate more favorable performance for this measure indicator (i.e., low rates of ED services may indicate better utilization of services). Therefore, percentiles were reversed to align with performance (e.g., the 10th percentile [a lower rate] was inverted to become the 90th percentile, indicating better performance).*

Table C-14—Utilization Performance Summary Stars (Table 2 of 2)[1]

MHP	*Risk of Continued Opioid Use—At Least 31 Days Covered—Total*	*Plan All-Cause Readmissions—Observed Readmissions—Total*	*Plan All-Cause Readmissions—Expected Readmissions—Total*	*Plan All-Cause Readmissions—O/E Ratio—Total*
AET	★	★	★	★
BCC	★	★★	★	★★
HAP	★	★★★	★	★★★★★
MCL	★	★★★	★★★	★★★
MER	★	★	★	★★
MOL	★	★★★	★★★	★★★
PRI	★	★★★★	★★★	★★★★
UNI	★	★★	★	★★★
UPP	★	★★★★★	★★	★★★★★

[1]*A lower rate may indicate more favorable performance for this measure indicator (i.e., low rates of ED services may indicate better utilization of services). Therefore, percentiles were reversed to align with performance (e.g., the 10th percentile [a lower rate] was inverted to become the 90th percentile, indicating better performance).*